MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02127 — 02078

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 6 mos. 8 dys.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1618 Gough Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANTHONY — Middle (NMN) — Last ADAMKOWICZ

4. DATE OF DEATH: Month February — Day 11 — Year 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ Sep.

8. DATE OF BIRTH: 12-03-86

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Iron Molder

10b. KIND OF BUSINESS OR INDUSTRY: Foundry

11. BIRTHPLACE (County & State, or foreign country): Poland

12. CITIZEN OF WHAT COUNTRY? Alien

13. FATHER'S NAME: Anthony Adamkowicz

14. MOTHER'S MAIDEN NAME: Franciska ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 217-01-3360A

17. INFORMANT: Records, Springfield State Hospital — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, probably gastro-intestinal, with metastasis to brain — INTERVAL BETWEEN ONSET AND DEATH: months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) ____
DUE TO (c) 5022 Moderately advanced pulmonary tuberculosis/ probably inactive — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic brain syndrome, associated with senile brain disease, with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8-3-65 19 to 2-11-66, 19 ____, that (I) (we) last saw the deceased alive on 2-11-66 19 ____, and that death occurred at 9:10 a.m. M, from the causes and on the date stated above.

22a. SIGNATURE: J. Radzykewycz M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 2-11-66

22c. PHYSICIAN'S NAME (Type): Julian A. Radzykewycz, M.D.

22d. ADDRESS: Springfield State Hospital, Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/15/66

23c. NAME OF CEMETERY OR CREMATORY: Holy Rosary

23d. LOCATION (City, town or county) (State): Baltimore, Maryland

24. FUNERAL DIRECTOR: M.F.SADOWSKI & SONS

ADDRESS: 1808 EASTERN AVE

25a. REC'D BY REGISTRAR DATE: FEB 14 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02128

CERTIFICATE OF DEATH

02079

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: CARROLL — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UNION BRIDGE RURAL
   c. LENGTH OF STAY IN 1b: 40 DAYS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): BROOK FIELD MANOR NURSING HOME

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: CARROLL
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NEW WINDSOR RURAL
   d. STREET ADDRESS: 06-1
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LULA Middle VIOLA Last ALBAUGH

4. DATE OF DEATH: Month FEB Day 8 Year 1966

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: APR 21, 1905

9. AGE (In years last birthday): 60 yrs. IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEKEEPER

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: ROSE NUSBAUM WESTMINSTER MD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 216-14-5739

17. INFORMANT: MRS OSCAR PETRY Address: RURAL NEW WINDSOR MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic C.V.D. — INTERVAL BETWEEN ONSET AND DEATH: Years

4221

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): ___

DUE TO (c): ___

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes + Ventral Hernia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11/10/60, 19___, to 2/8/66 19___, that (I) ~~(we)~~ last saw the deceased alive on 2/6/66 19___, and that death occurred at 7:30 AM, from the causes and on the date stated above.

22a. SIGNATURE: M. E. Robertson — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/8/66

22c. PHYSICIAN'S NAME (Type): M E ROBERTSON

22d. ADDRESS: NEW WINDSOR MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 2/11/66

23c. NAME OF CEMETERY OR CREMATORY: PIPE CREEK

23d. LOCATION (City, town or county) (State): CARROLL CO MD

24. FUNERAL DIRECTOR: D D Hartzler & Sons ADDRESS: New Windsor Md

25a. REC'D BY REGISTRAR DATE: FEB 11 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02129. 02081

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Carroll Co. — MARYLAND — b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): — c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Carroll Co. General Hosp

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) — a. STATE: Md — b. COUNTY: Carroll — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster 26-1 — d. STREET ADDRESS: Pleasant Valley — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: E. — Last: Ball Sr

4. DATE OF DEATH: Month: Feb. — Day: 24 — Year: 66

5. SEX: M — 6. COLOR OR RACE: W — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: Dec. 21 92 — 9. AGE (In years last birthday): 73 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): — 10b. KIND OF BUSINESS OR INDUSTRY: — 11. BIRTHPLACE (County & State, or foreign country): Balto. Md — 12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: Henry W. Ball — 14. MOTHER'S MAIDEN NAME: Carrie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): — 16. SOCIAL SECURITY NO.: 215-05-9110 — 17. INFORMANT: Mrs. Catherine E. Ball — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH:
4200
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): with thrombo embolic involvement — 10 days
DUE TO (c): L. Leg Gangrene

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year / Hour a.m. p.m. 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/23, 19 66, to 2/24, 19 66, that (I) (we) last saw the deceased alive on 2/23, 19 66, and that death occurred at 2 M, from the causes and on the date stated above.

22a. SIGNATURE: Richard G. Dalrymple M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐ — 22b. DATE SIGNED: 2/24/66

22c. PHYSICIAN'S NAME (Type): RICHARD G. DALRYMPLE — 22d. ADDRESS: #13 Hoppe Glen Westminster

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 2/26/66 — 23c. NAME OF CEMETERY OR CREMATORY: Woodlawn — 23d. LOCATION (City, town or county) (State): Balto Md

24. FUNERAL DIRECTOR: Wilfley F.D. — ADDRESS: 4101 Edmondson Ave — 25a. REC'D BY REGISTRAR DATE: FEB 28 1966 — 25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02130

CERTIFICATE OF DEATH

02081

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Taneytown
   c. LENGTH OF STAY IN 1b: 14 Yrs.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 31 York St.

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Carroll
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Taneytown
   d. STREET ADDRESS: 31 York St.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Basil — Middle: Crawford — Last: BANKS

4. **DATE OF DEATH**: Month: Feb. — Day: 27 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 27, 1889

9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Insurance Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Insurance

11. BIRTHPLACE (County & State, or foreign country): [redacted] Montgomery Co.

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Thomas Banks

14. MOTHER'S MAIDEN NAME: Mary Crawford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 160-07-4049

17. INFORMANT: Mrs. Margaret E. Banks — Address: 31 York St. Taneytown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary Occlusion	6 hrs
DUE TO (b)	Coronary Sclerosis	5 yrs
DUE TO (c)	Hypertensive Cardiovascular Disease	10 yrs

4201

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Duodenal Ulcer, Chronic Anxiety State

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) ~~(this hospital)~~ attended the deceased from June 12, 1958 to Feb 27, 1966 that (I) ~~(we)~~ last saw the deceased alive on Feb 27 1966, and that death occurred at 9 A.M. from the causes and on the date stated above.

22a. SIGNATURE: E. Ambler Thompson M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/28/66

22c. PHYSICIAN'S NAME (Type): E. Ambler Thompson, M.D.

22d. ADDRESS: Taneytown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: March 2, 1966 — 23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet — 23d. LOCATION (City, town or county) (State): Frederick Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond E. Yeager — ADDRESS: Thurmont, Md.

25a. REC'D BY REGISTRAR DATE: MAR 3 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A1S (4)
20M 5-63

x

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02131 — 02082

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Middleburg-Union Bridge
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Brookfield Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural- New Windsor
d. STREET ADDRESS: none
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	Pearlie	Mae	Barnes		Feb.	28	1966

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White		August 28, 1886	79 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
practical nurse	nursing	Frederick Co. Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Frank W. Barnes	Laura Nusbaum

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown)	(If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
no	none	UNKNOWN	Mrs. Roy Franklin	Rural New Windsor, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic C.V.D. — INTERVAL BETWEEN ONSET AND DEATH: years

4221

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. / Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. **I certify** that (I) (this hospital) attended the deceased from 12/1/45, 19..., to 2/28/46 19..., that (I) (we) last saw the deceased alive on 2/28/46 19..., and that death occurred at 4:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE	M.D.	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
M. E. Robertson			2/28/46

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
M. E. Robertson	New Windsor, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	3/2/66	Linganore Cemetery	Unionville Maryland

24 FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
D.D. Hartzler & Sons	New Windsor	MAR 3 1966	Charles Judge

VR A1S (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02132 02083

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: CARROLL
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1yr,8mo,16das.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 2 West University Parkway,Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROBERT Middle PAUL Last BAUER

4. DATE OF DEATH: Month February Day 18 Year 1966

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12-6-88
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): bookkeeper -retired
10b. KIND OF BUSINESS OR INDUSTRY: Bookkeeping
11. BIRTHPLACE (County & State, or foreign country): U.S.A.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert J. Bauer
14. MOTHER'S MAIDEN NAME: Mary Gerben

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no
(If yes give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Records, Springfield State Hospital
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: days
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying ceuse last.
DUE TO (b): Myocardidl infarction — days
DUE TO (c): Arteriosclerotic cardiovascular disease — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
Chronic brain syndrome assoc. with cerebral arterio. without qualifying phrase. Schizophrenic reaction, simple type.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED: (Enter neture of injury in Part I or Part II of Item 18.)

2Dc. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
2Dd. INJURY OCCURRED While at work ☐ Not While at work ☐
2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6-3-64, 19__ to 2-18-66, 19__, that (I) (we) last saw the deceased alive on 2-18-66 19__, and that death occurred at 2:40 PM, from the causes and on the date stated above.

22a. SIGNATURE: Naci N. Buyukunsal M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 2-18-66
22c. PHYSICIAN'S NAME (Type): Naci N. Buyukunsal, M.D.
22d. ADDRESS: Springfield State Hospital, Sykesville

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/22/1966
23c. NAME OF CEMETERY OR CREMATORY: Loudon Park
23d. LOCATION (City, town or county) (State): Baltimore, Md.

24. FUNERAL DIRECTOR ADDRESS: H.W.Jenkins & Sons Co. 4905 York Road Baltimore, 12, Md.
25a. REC'D BY REGISTRAR DATE: FEB 21 1966
25b. REGISTRAR'S SIGNATURE: J.Charles Judge

VR A15 (4)
15M 4-64

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02133 02084

1. PLACE OF DEATH
a. COUNTY: Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1yr.2mos.5dys.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto. City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 2042 E. Hoffman St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JUNIOR Middle (nmn) Last BUCHANAN
4. DATE OF DEATH: Month FEBRUARY Day 23 Year 19 66
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-2-95
9. AGE (In years last birthday): 70 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shipyard Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): South Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Moses Buchanan
14. MOTHER'S MAIDEN NAME: Lizzie ?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT Address: Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gangrene, right leg — INTERVAL BETWEEN ONSET AND DEATH: Weeks
4501
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Severe arteriosclerosis — Years
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome associated with central nervous system syphilis, meningovascular, with psychotic reaction, 0264 — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12-18-64, 19__, to 2-23, 1966, that (I) (we) last saw the deceased alive on 2-23 19 66, and that death occurred at 8:45 AM, from the causes and on the date stated above.

22a. SIGNATURE: Robert M. Deeb M.O. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 2-23-66
22c. PHYSICIAN'S NAME (Type): Robert M. Deeb, M. D.
22d. ADDRESS: Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 2/28/66
23c. NAME OF CEMETERY OR CREMATORY: Mt. CALVARY
23d. LOCATION (City, town or county) (State): A.A. County, Md

24. FUNERAL DIRECTOR ADDRESS: Joseph L. Locke 1304 N. Central Ave
25a. REC'D BY REGISTRAR DATE: FEB 25 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02134 — 02085

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Manchester
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Long View Nursing Home, 128 N. Main St

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Carroll
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hampstead — 06-1
   d. STREET ADDRESS: 143, Willow Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Thomas — Middle: Wilson — Last: Buchman, Sr.

4. **DATE OF DEATH**: Month: February — Day: 8 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2-28-1873

9. AGE (In years last birthday): 92 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School teacher

10b. KIND OF BUSINESS OR INDUSTRY: Education

11. BIRTHPLACE (County & State, or foreign country): Carroll Co Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Peter Buchman

14. MOTHER'S MAIDEN NAME: Mary Ruth Allgire

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Francis Buchman — Address: Hampstead, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pneumonitis

4221

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic Cardiovascular disease

DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY ~~MEDICAL EXAMINER~~)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day, Year — 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1-28, 1966, to 2-8-, 1966 that (I) (we) last saw the deceased alive on 2-8 1966, and that death occurred at 6:40 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Joseph E. Bush M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/9/66

22c. PHYSICIAN'S NAME (Type): Joseph E. Bush MD

22d. ADDRESS: Hampstead Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2-11-66

23c. NAME OF CEMETERY OR CREMATORY: Wesley Cemetery

23d. LOCATION (City, town or county): Carroll Co. (State): Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Tipton-Eline — ADDRESS: Hampstead, Md.

25a. REC'D BY REGISTRAR DATE: FEB 15 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02135 02086

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): (Rural) Sykesville
c. LENGTH OF STAY IN 1b: Oy Om 6d
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Baltimore 21218
d. STREET ADDRESS: 706 E. 37th. Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John — Middle Sherman — Last Byers
4. DATE OF DEATH: Month 2 — Day 21 — Year 1966
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 5-4-82
9. AGE (In years last birthday): 83 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Metallurgist - Retired U.S.Gov't.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Isaac Byers
14. MOTHER'S MAIDEN NAME: Viola Leach
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): None (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 218-22-0363
17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Terminal pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days
4200
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic heart disease — years
DUE TO (c): General arteriosclerosis — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic brain syndrome associated with senile brain disease without qualifying phrase
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): ----
20c. TIME OF INJURY Hour a.m. p.m. --- Month, Day, Year --- 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ---
20f. (City or town) -- (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from 2-15, 1966, to 2-21, 1966, that (☒ (we) last saw the deceased alive on 2-21 1966, and that death occurred at 6:25 PM, from the causes and on the date stated above.

22a. SIGNATURE: Myron Nizankowsky — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 2-21-66
22c. PHYSICIAN'S NAME (Type): Myron Nizankowsky, M.D.
22d. ADDRESS: Springfield State Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/24/1966
23c. NAME OF CEMETERY OR CREMATORY: Moreland Memorial Pk.
23d. LOCATION (City, town or county) (State): Parkville, Balto.Co.Md.
24. FUNERAL DIRECTOR: H.W.Jenkins & Sons Co. ADDRESS: 4905 York Road Balto.12, Md.
25a. REC'D BY REGISTRAR DATE: FEB 23 1966
25b. REGISTRAR'S SIGNATURE: J.Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02136 — 02087

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 9 mo. 11 da.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 3714 Northern Parkway (115 East Melrose Avenue) — RESIDENCE ON FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Dennis — Middle: James — Last: Byrne, Sr.
4. DATE OF DEATH: Month: 2 — Day: 19 — Year: 1966
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12-31-79
9. AGE (In years last birthday): 86 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Patrick Byrne
14. MOTHER'S MAIDEN NAME: Mary Roche (maiden name unknown)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 218-05-1204A
17. INFORMANT — Address: Springfield records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Nephrosclerosis - uremia	years
DUE TO (b)	Arteriosclerotic heart disease	years
DUE TO (c)	Generalized arteriosclerosis	years

4200
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic brain syndrome associated with cerebral arteriosclerosis without qualifying phrase

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-8- 1965, to 2-19, 1966, that (I) (we) last saw the deceased alive on 2-19- 1966, and that death occurred at 1:25 p.m. the causes and on the date stated above.

22a. SIGNATURE: S. Ozgun — M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 2-19-66
22c. PHYSICIAN'S NAME (Type): S. Ozgun, M.D.
22d. ADDRESS: Springfield State Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 2-23-66
23c. NAME OF CEMETERY OR CREMATORY: Parkwood Cemetery
23d. LOCATION (City, town or county) (State): Baltimore, Md.

24. FUNERAL DIRECTOR — ADDRESS: Leonard J. Ruck Inc Baltimore, Md.
25a. REC'D BY REGISTRAR — DATE: FEB 23 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02137 02088

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Sykesville
c. LENGTH OF STAY IN 1b 6 Months
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Melville Ave.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville 06-1
d. STREET ADDRESS Melville Ave. e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First MARY Middle E. Last Chambers
4. DATE OF DEATH Month Feb. Day 13, Year 1966
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH MARCH 9, 1880
9. AGE (In years last birthday) 85 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) No (If yes give war or dates of service) —
16. SOCIAL SECURITY NO. 213-16-3513
17. INFORMANT Mr. Edward Chambers Address Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Nov. 1965
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Hypertension; arteriosclerosis, generalized — 2-13-66
DUE TO (c) Chronic brain sindrome

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from November, 1965, to Feb. 13, 1966, that (I) (we) last saw the deceased alive on Feb. 13 1966, and that death occurred at 1 P.M., from the causes and on the date stated above.

22a. SIGNATURE Howard E Hall M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED Feb. 14, 1966
22c. PHYSICIAN'S NAME (Type) Howard E. Hall, M.D.
22d. ADDRESS Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 2-16-66
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery
23d. LOCATION (City, town or county) (State) Baltimore, Md.
24. FUNERAL DIRECTOR ADDRESS Harry W. Haight Sykesville, Md.
25a. REC'D BY REGISTRAR DATE FEB 21 1966
25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02138 — 02089

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 2800 Reisterstown, Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Helen; Middle: MARY; Last: CLINTON
4. DATE OF DEATH: Month: Feb; Day: 13; Year: 1966
5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8-31-31
9. AGE (In years last birthday): 34 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baker
10b. KIND OF BUSINESS OR INDUSTRY: Bakery
11. BIRTHPLACE (County & State, or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Howard Clinton
14. MOTHER'S MAIDEN NAME: Shelton Avery - N. Carolina
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 238-38-6140
17. INFORMANT: Hospital Records
Address: Springfield State Hosp. Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute cardiac dilatation
443X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertensive vascular disease
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: Minutes / Years ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ~~I~~ (this hospital) attended the deceased from Feb. 10, 1966, to Feb. 13, 1966, that ~~I~~ (we) last saw the deceased alive on 2/13 1966, and that death occurred at 3:15 ~~P~~ M, from the causes and on the date stated above.

22a. SIGNATURE: [signature]
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Dr. Samuel P. Wise IV
22d. ADDRESS: S.S. Hospital Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/16/66
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d. LOCATION (City, town or county) (State): Gastonia N.C.

24. FUNERAL DIRECTOR ADDRESS: Herbert E. Nutter-3035 W. North Ave.
25a. REC'D BY REGISTRAR DATE: FEB 15 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02139

CERTIFICATE OF DEATH

02090

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
c. LENGTH OF STAY IN 1b: 19HRS 21M
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Carroll County General

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 309 Main St — 06-1
d. STREET ADDRESS: New Windsor
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Michelle — Middle: Anne — Last: Coe

4. DATE OF DEATH: Month: 2 — Day: 6 — Year: 19 66

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/8/66

9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months — Days — Hours: 19 — Min.: 21
IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: ~~Edward~~ Rodney Valentine ~~Coe~~

14. MOTHER'S MAIDEN NAME: Constance Coe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: Constance Coe — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Immaturity (Birthwgt 1'11½) — INTERVAL BETWEEN ONSET AND DEATH
7615
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Premature Labor + partial Separation placenta

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 2-6, 1966, to 2-6, 1966, that (I) (we) last saw the deceased alive on 19, and that death occurred at 8:22 pM, from the causes and on the date stated above.

22a. SIGNATURE: Karl M Green — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/6/66

22c. PHYSICIAN'S NAME (Type): KARL M GREEN

22d. ADDRESS: Westminster

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 2-9-66

23c. NAME OF CEMETERY OR CREMATORY: PIPE CREEK CEM.

23d. LOCATION (City, town or county) (State): CARROLL COUNTY MD

24. FUNERAL DIRECTOR: D.D. Hartzler Sons — ADDRESS: New Windsor Md

25a. REC'D BY REGISTRAR DATE: FEB 11 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

6-1974 66

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02140

CERTIFICATE OF DEATH

02091

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 2yrs.7mos.28dys.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Garrett
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Addison, Pa. (Garrett Co.)
d. STREET ADDRESS: 11-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RAY — Middle JOHNSON — Last CROWTHERS

4. DATE OF DEATH: Month FEBRUARY — Day 8 — Year 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11-15-1886

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Druggist (retired)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unk.

14. MOTHER'S MAIDEN NAME: Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Unk. (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 172-07-1463

17. INFORMANT Address: Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: Years
4200
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Generalized arteriosclerosis — Years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): CBS assoc. with cerebral arteriosclerosis, with psychotic reaction

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6-10-63, 19__, to 2-8-66, 19__, that (I) (we) last saw the deceased alive on 2-8-66 19__, and that death occurred at 5:04 AM, from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 2-8-66

22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M. D.

22d. ADDRESS: Springfield State Hospital, Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/10/66

23c. NAME OF CEMETERY OR CREMATORY: Addison, Pa. Cemetery

23d. LOCATION (City, town or county) (State): Addison, Somerset, Pa.

24. FUNERAL DIRECTOR: Ruth E. Newman — ADDRESS: Grantsville, Md.

25a. REC'D BY REGISTRAR DATE: FEB 11 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02141

CERTIFICATE OF DEATH

02092

1. **PLACE OF DEATH** a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): WESTMINSTER
c. LENGTH OF STAY IN 1b: 72 YRS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 70 LIBERTY ST.

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER 06-1
d. STREET ADDRESS: 70 LIBERTY ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. **NAME OF DECEASED** (Type or print): First ELIZABETH Middle REBECCA Last DAVIS

4. **DATE OF DEATH**: Month FEB. Day 22 Year 1966

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: MARCH 7, 1866

9. AGE (In years last birthday): 99 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): home-wife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): Carroll Co. Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Gideon Cook

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Mr. John Case Address: 70 Liberty St. Westminster Md

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 1 2HRS
4201
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): CORONARY ARTERIOSCLEROSIS — 10 YRS
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from SEPT., 1961, to FEB 22 1966, that (I) (we) last saw the deceased alive on FEB 22 1966, and that death occurred at 10:38 AM, from the causes and on the date stated above.

22a. SIGNATURE: William L. Stewart, M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/22/66

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS: 19 RIDGE RD. WESTMINSTER, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/25/66

23c. NAME OF CEMETERY OR CREMATORY: Deer Park Cemetery

23d. LOCATION (City, town or county) (State): Smallwood Carroll Co. Md.

24 FUNERAL DIRECTOR'S SIGNATURE: J. E. Myers Jr. ADDRESS: Westminster Md

25a. REC'D BY REGISTRAR DATE: FEB 28 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
20M S-63

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02142 02093

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural--Sykesville
c. LENGTH OF STAY IN 1b: 3yrs. 24days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
d. STREET ADDRESS: 60 Pennsylvania Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: GRACE Middle: Steel Last: Day
4. DATE OF DEATH: Month: Feb Day: 3 Year: 19-66

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10/31/88
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William R. Steele
14. MOTHER'S MAIDEN NAME: Elizabeth Crowl

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: unknown
17. INFORMANT Address: Springfield Hospital records, Sykesville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Terminal pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days
4221
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic cardiovascular disease — years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic brain syndrome with senile brain disease with psychotic reaction.
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from 1/91, 1963, to 2/31, 1966, that ☐ (we) last saw the deceased alive on 2/31 1966, and that death occurred at 8:20 PM, from the causes and on the date stated above.

22a. SIGNATURE: S. P. Wise III — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2/3/66
22c. PHYSICIAN'S NAME (Type): Samuel P. Wise, III, M.D.
22d. ADDRESS: Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/8/66
23c. NAME OF CEMETERY OR CREMATORY: Evergreen Mem. Gardens
23d. LOCATION (City, town or county) (State): Finksburg RD. Md.

24. FUNERAL DIRECTOR: E. E. Myers, Jr. ADDRESS: Westminster, Md.
25a. REC'D BY REGISTRAR DATE: FEB 7 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02143

CERTIFICATE OF DEATH

02094

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville
   c. LENGTH OF STAY IN 1b: 3yrs.9mos.6dys.
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Frederick
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Myersville
   d. STREET ADDRESS: Box 7
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
EFFIE	HILDEBRANDT	DEAN	FEBRUARY	15	1966

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White		11-30-1874	91 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	-	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Hildebrandt	Sophie Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	(none)	Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Pneumonitis	3 days
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b)	Arteriosclerotic cardiovascular disease	years
DUE TO (c)		

4221

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic brain syndrome with cerebral arteriosclerosis, with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that ~~I~~ (this hospital) attended the deceased from May 9, 1962, to Feb. 15, 1966, that ~~I~~ (we) last saw the deceased alive on Feb. 15 1966, and that death occurred at 12:30 A.M., from the causes and on the date stated above.

22a. SIGNATURE	M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22b. DATE SIGNED
Ilse Kamm		2-15-66

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
Ilse Kamm, M.D.	Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	Feb 17, 1966	St. Pauls Lutheran	Myersville, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Paul F. Bittle	Myersville, Md.	FEB 17 1966	J. Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02144

CERTIFICATE OF DEATH

02095

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1yr.1mos.20dys.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1715 Madison Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HENRY Middle JAMES Last De JOURNETT
4. DATE OF DEATH: Month February Day 22 Year 1966

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3-15-96
9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Alabama
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph DeJournett
14. MOTHER'S MAIDEN NAME: Littie ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT Address: Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Extensive bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: days
491
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic brain syndrome, associated with cerebral arteriosclerosis, with psychotic reaction. Carcinoma of floor of mouth.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10-2-64, 19, to 2-22-66, 19, that (I) (we) last saw the deceased alive on 2-22-66 19, and that death occurred at 4:30 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Frances Reid Nabors, M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 2/22/66
22c. PHYSICIAN'S NAME (Type): Frances Reid Nabors, M.D.
22d. ADDRESS: Springfield State Hospital, Sykesville, Maryland 21784

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE THEREOF: 2-25-66
23c. NAME OF CEMETERY OR CREMATORY: Bloom Memorial Park
23d. LOCATION (City, town or county) (State): BALTIMORE Md.
24. FUNERAL DIRECTOR: Frank H. Reed — ADDRESS: Pikesville, Md.
25a. REC'D BY REGISTRAR DATE: MAR 1 1966
25b. REGISTRAR'S SIGNATURE: Charles Yunge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02145

CERTIFICATE OF DEATH

02096

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville
   c. LENGTH OF STAY IN 1b: 26yrs.9mos.6dys.
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Garrett
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oakland
   d. STREET ADDRESS: (unknown)
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: RAY — Middle: (None) — Last: DeWITT

4. DATE OF DEATH: Month: FEBRUARY — Day: 15 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-11-01

9. AGE (In years last birthday): 65 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harris DeWitt

14. MOTHER'S MAIDEN NAME: Susan DeWitt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: (none)

17. INFORMANT — Address: Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

4221

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic cardiovascular disease
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic Brain Syndrome with convulsive disorder, with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ~~(I)~~ (this hospital) attended the deceased from May 9, 1939, to Feb. 15, 1966, that ~~(I)~~ (we) last saw the deceased alive on Feb. 15 1966, and that death occurred at 4:15 ~~A~~ P.M., from the causes and on the date stated above.

22a. SIGNATURE: Ilse Kamm M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ — 22b. DATE SIGNED: 2-15-66

22c. PHYSICIAN'S NAME (Type): Ilse Kamm, M.D.

22d. ADDRESS: Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 2/18/66 — 23c. NAME OF CEMETERY OR CREMATORY: Gortner Cemetery — 23d. LOCATION (City, town or county) (State): Garrett Co. Md.

24. FUNERAL DIRECTOR — ADDRESS: Gerald N. Munnell Oakland, Md.

25a. REC'D BY REGISTRAR DATE: FEB 21 1966 — 25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02146

CERTIFICATE OF DEATH

02097

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: CARROLL
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): WESTMINSTER
   c. LENGTH OF STAY IN 1b: 66 YEARS
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): GEORGE ST. EXTD.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: CARROLL
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER 86-1
   d. STREET ADDRESS: GEORGE ST. EXTD
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MABEL Middle ELOISE Last DICKERSON

4. DATE OF DEATH: Month FEB. Day 20 Year 1966

5. SEX: FEMALE

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: APRIL 1 1899

9. AGE (In years last birthday): 66 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): WESTMINSTER, MD. U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: COLUMBUS SHEEN

14. MOTHER'S MAIDEN NAME: MARY C. JACKSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): —
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: MRS CATHERINE CHASE, SAME
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary insufficiency and occlusion — INTERVAL BETWEEN ONSET AND DEATH: 12hrs

4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): arteriosclerosis — 3+ yrs
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 7, 1960, to Feb 20, 1966, that (I) (we) last saw the deceased alive on Jan 6 1966 and that death occurred at ____M, from the causes and on the date stated above.

22a. SIGNATURE: E Reese Wilkens M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Feb 22, 1966

22c. PHYSICIAN'S NAME (Type): E. Reese Wilkens

22d. ADDRESS: 15 Ramper Ave Westminster Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 2/23/66

23c. NAME OF CEMETERY OR CREMATORY: GARDEN OF ETERNAL HOPE

23d. LOCATION (City, town or county) (State): FINKSBURG MD.

24. FUNERAL DIRECTOR ADDRESS: J. S. Rogers Jr. Westminster, Md

25a. REC'D BY REGISTRAR DATE: FEB 23 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02147

CERTIFICATE OF DEATH

Reg. Dist. No. 02098

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 4 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Golden Age Guest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Reisterstown 03-2
d. STREET ADDRESS: 84 Sacred Heart Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Marie; Middle: Kahl; Last: Diehl

4. DATE OF DEATH: Month: February; Day: 3; Year: 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec. 21, 1881

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Henry Kahl

14. MOTHER'S MAIDEN NAME: Christina

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. Frederick Warnken — Address: 84 Sacred Heart Lane Reisterstown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchial pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypostatic pneumonia — 1 year
DUE TO
(c) A.S.C.V.D. — 10 yrs.

4221

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 26, 1966, to February 3, 1966, that I last saw the deceased alive on February 3, 1966, and that death occurred at 5:45 pM, from the causes and on the date stated above.

ACTUAL SIGNATURE: R. V. Houck M.D. — ADDRESS (Street, city or town, state): Liberty Road — DATE SIGNED: 2-3-66

PHYSICIAN'S NAME (Type): R. V. Houck, Jr. M.D. — Sykesville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/5/66
22c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery
22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: H. J. Eckhardt — ADDRESS: Owings Mills, Md.

24a. REC'D BY REGISTRAR DATE: FEB 8 1966

24b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02148 02049

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Middleburg
c. LENGTH OF STAY IN 1b: 5weeks
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Brookfield Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Taneytown
d. STREET ADDRESS: 06-1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Myrtle — Middle: Tora — Last: Dignan

4. DATE OF DEATH: Month: February — Day: 19, — Year: 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: May 30, 1887

9. AGE (In years last birthday): 78 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (County & State, or foreign country): Slanesville, West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward B. Miller

14. MOTHER'S MAIDEN NAME: Laura E. Pugh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mr. Jack C. Jenkins, R #1, Taneytown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bilateral Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH
491X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): ① Multiple Sclerosis ② Generalized atherosclerosis

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

2Da. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/9/66, 19__, to 2/19/66, 19__, that (I) (we) last saw the deceased alive on 2/19/66 19__, and that death occurred at 1:36 M, from the causes and on the date stated above.

22a. SIGNATURE: J. H. Carmicofe — ATTENDING PHYS. M.D. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 2/19/66

22c. PHYSICIAN'S NAME (Type): J. H. Carmicofe

22d. ADDRESS: Union Bridge, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb. 22, 1966

23c. NAME OF CEMETERY OR CREMATORY: Camp Hill Cemetery

23d. LOCATION (City, town or county) (State): Paw Paw, West Virginia

24. FUNERAL DIRECTOR: C.O.Fuss & Son — ADDRESS: John H. Stiles, Taneytown, Maryland

25a. REC'D BY REGISTRAR DATE: FEB 23 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02143 — 02100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
1SM 7/61

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL WESTMINSTER
c. LENGTH OF STAY IN 1b: 28 YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 32 CHARLES ST.

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL - WESTMINSTER
d. STREET ADDRESS: 32 CHARLES ST 06-1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: CATHERINE — Middle: LUCINDA — Last: DORM

4. DATE OF DEATH: Month: FEB — Day: 15 — Year: 1966.

5. SEX: FEMALE

6. COLOR OR RACE: NEGRO

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: DEC 22 1905

9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): CARROLL MARYLAND

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ANDREW DORSEY

14. MOTHER'S MAIDEN NAME: LUCINDA GREY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT Address: MRS. JESSIE COOK. WESTMINSTER MARYLAND.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CONGESTIVE HEART FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 3 WEEKS

416 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): RHEUMATIC HEART DISEASE — 20 YEARS

DUE TO (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from FEB 1958 to FEB 1966 that (I) (we) last saw the deceased alive on FEB 15 1966., and that death occured at 1:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Daniel I Welliver M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2-15-66

22c. PHYSICIAN'S NAME (Type): DANIEL I. WELLIVER

22d. ADDRESS: 19 RIDGE ROAD WESTMINSTER MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/19/66

23c. NAME OF CEMETERY OR CREMATORY: Gardens of Eternal Hope

23d. LOCATION (City, town or county) (State): Finksburg Rd Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: J. E. Myers Jr. Westminster, Md

25a. REC'D BY REGISTRAR DATE: FEB 17 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02150

CERTIFICATE OF DEATH

02101

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Westminster
c. LENGTH OF STAY IN 1b: Birthplace
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Carroll County General

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville 06-1
d. STREET ADDRESS: Rte 2 Box 278A
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Dean — Middle: Allen — Last: Dustin

4. DATE OF DEATH: Month: 2 — Day: 1 — Year: 1966

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 2/1/66

9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: 11 — Min.: 37

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): no

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Carroll Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Donald E. DUSTIN

14. MOTHER'S MAIDEN NAME: LAWANNA WEAKLEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): - - - - -

16. SOCIAL SECURITY NO.: N/A

17. INFORMANT: Mr. Donald Dustin, Same as #2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — Aspiration of Meconium — INTERVAL BETWEEN ONSET AND DEATH: Birth
7610
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Apnea Neonatorum and Intracranial Hemorrhage — Birth
DUE TO (c): Placenta Previa — Birth

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2-1, 1966, to 2-1, 1966, that (I) (we) last saw the deceased alive on 2-1 1966, and that death occurred at 10:37 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Karl M Green

ATTENDING M.D. PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 2/4/66 5:30 Am.

22c. PHYSICIAN'S NAME (Type): KARL M. Green, MD.

22d. ADDRESS: 171 Fairfield Ave., Westminster

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: FEB. 5, 1966

23c. NAME OF CEMETERY OR CREMATORY: Emmanual Church Cemetery,

23d. LOCATION (City, town or county) (State): Scaggsville, Maryland

24. FUNERAL DIRECTOR — ADDRESS: Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland

25a. REC'D BY REGISTRAR DATE: FEB 4 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

6-147453

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02151

CERTIFICATE OF DEATH

02102

1. PLACE OF DEATH
a. COUNTY: Carroll
MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 11 yrs. 8mos.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore city
d. STREET ADDRESS: 125 N. Broadway
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First Jacob Middle (FREEMAN) NMN Last Friedman

4. DATE OF DEATH: Month Febuary Day 6 Year 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X]

8. DATE OF BIRTH: 8-21-1900

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Whiskey Salesman

10b. KIND OF BUSINESS OR INDUSTRY: ~~WHISKEY~~ WHISKEY

11. BIRTHPLACE (County & State, or foreign country): Maryland, BALTIMORE

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Philip Friedman

14. MOTHER'S MAIDEN NAME: Rosa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: UNKnown

17. INFORMANT Address: Springfield State Hosp. Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia (Extensive)
491 X
INTERVAL BETWEEN ONSET AND DEATH: Days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Schizophrenic reaction Paranoid type

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6-14-, 19 54, to 2-6-, 1966, that (I) (we) last saw the deceased alive on 2-6-66, 19 66, and that death occurred at 9:30 AM, from the causes and on the date stated above.

22a. SIGNATURE: Octavio A Ruiz
M.D. ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]

22b. DATE SIGNED: 2-6-66

22c. PHYSICIAN'S NAME (Type): Dr. Octavio Ruiz

22d. ADDRESS: Springfield State Hosp. Sykesville, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 2/8/66

23c. NAME OF CEMETERY OR CREMATORY: BETH JACOB ANSHE VESHEAR

23d. LOCATION (City, town or county) (State): ROSEDALE, MARYLAND

24. FUNERAL DIRECTOR: SOL LEVINSON & BROS. INC.

ADDRESS: 6010 REISTERSTOWN RD

25a. REC'D BY REGISTRAR DATE: FEB 11 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02152 02103

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Sykesville
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Sykesville 06-1
d. STREET ADDRESS: Barrett
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ELLA Middle: FRIZZELL Last:
4. DATE OF DEATH: Month: Feb. Day: 2 Year: 1966
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 24 1879
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (County & State, or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Payton Frizzell
14. MOTHER'S MAIDEN NAME: Sarah Amanda Wilcox
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mrs Frank A. Dorsey — Address: Westminster, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	HYPERTENSIVE CARDIOVASCULAR DISEASE	30+ yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	GENERAL ARTERIOSCLEROSIS	30+ yrs
DUE TO (c)	ADVANCED SENILE CHANGES	

443X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
2Dd. INJURY OCCURRED While at work ☐ Not While at work ☐
2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1935, 19__, to 2/Feb/, 1966, that (I) (we) last saw the deceased alive on 2/Feb/66 19__, and that death occurred at 2:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Wm H Lawson
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2/Feb/66
22c. PHYSICIAN'S NAME (Type): Wm. H. Lawson, Jr., M.D.
22d. ADDRESS: Box 54 RD #2, Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2-5-66
23c. NAME OF CEMETERY OR CREMATORY: Freedom
23d. LOCATION (City, town or county) (State): Sykesville, Carroll Co., Md

24. FUNERAL DIRECTOR: Luther A. Haight ADDRESS: Sykesville, Md.
25a. REC'D BY REGISTRAR DATE: FEB 7 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4) 2DM 1/65

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02153

CERTIFICATE OF DEATH

02104

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Carroll
   MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural-Union Bridge, Md.
   c. LENGTH OF STAY IN 1b: 10 yrs
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): R.D. 2

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Carroll
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural--Union Bridge
   d. STREET ADDRESS: R.D. 2
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES Middle E. Last GARBER

4. DATE OF DEATH: Month FEB. Day 12, Year 1966

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2-28-1877

9. AGE (In years last birthday): 88 yrs.
   IF UNDER 1 YEAR: Months ___ Days ___
   IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired farmer

10b. KIND OF BUSINESS OR INDUSTRY: own

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Abiel Garber

14. MOTHER'S MAIDEN NAME: Sarah Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no
    (If yes give war or dates of service): ----

16. SOCIAL SECURITY NO.: 219-14-8802

17. INFORMANT Address: Mrs. Roger Lawrence, same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral anoxia — INTERVAL BETWEEN ONSET AND DEATH: Unknown
293 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Anemia
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Carcinoma - Probably stomach -

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/12, 1966, to 2/12, 1966, that (I) (we) last saw the deceased alive on 2/12 1966, and that death occurred at 5'9 M, from the causes and on the date stated above.

22a. SIGNATURE: William R O'Rourke M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/13/66

22c. PHYSICIAN'S NAME (Type): William O'Rourke

22d. ADDRESS: 150 W. Main St. Westminster Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 2-15-1966

23c. NAME OF CEMETERY OR CREMATORY: Linganore

23d. LOCATION (City, town or county) (State): Frederick Co., Maryland

24. FUNERAL DIRECTOR ADDRESS: C.M.Waltz, Box 241, Sykesville, Md.

25a. REC'D BY REGISTRAR DATE: FEB 15 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
15M 4-64

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02154 02105

1. PLACE OF DEATH
a. COUNTY: Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural--Sykesville
c. LENGTH OF STAY IN 1b: 12y. 5m. 27d.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 303 Imla Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elizabeth Middle: - Last: Gilden

4. DATE OF DEATH: Month: 2 Day: 7 Year: 1966

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9/28/79

9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Firmstein

14. MOTHER'S MAIDEN NAME: Barbara Welch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: none known

17. INFORMANT Address: Springfield State Hospital records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), end (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: days

4221

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic cardiovascular disease — years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic brain syndrome with changes of growth, metabolism or nutrition with senile brain disease with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from 8/10/ , 19 53, to 2/7/ , 1966, that ☒ (we) last saw the deceased alive on 2/7/ 1966, and that death occurred at 10:50 p.m. from the causes and on the date stated above.

22a. SIGNATURE: Naci Nejat Buyukunsal M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 2/8/66

22c. PHYSICIAN'S NAME (Type): Naci Nejat Buyukunsal, M.D.
22d. ADDRESS: Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/10/66
23c. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cemetery
23d. LOCATION (City, town or county) (State): Baltimore Md.

24. FUNERAL DIRECTOR: Edward L. Lilly, President Lilly & Zeiler Inc. F. H.
ADDRESS: 1901 Eastern Ave Baltimore, 31, Md.

25a. REC'D BY REGISTRAR DATE: FEB 14 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4) 20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02155 — 02106

1 (M) (I)

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville Rd
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Golden Age Guest Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ABINGDON 12-2
d. STREET ADDRESS: 4102 BAKER ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

90

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Gordon — Last:

4. DATE OF DEATH: Month: Feb. — Day: 1st — Year: 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Nov. 4, 1881

9. AGE (In years last birthday): 84 yrs.

IF UNDER 1 YEAR: Months: — Days:
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): DAYTON Md.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: HENRY PEDDICORD

14. MOTHER'S MAIDEN NAME: IDA V THOMPSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT Address: ALVIN B GORDON, 4102 BAKER AVE, ABINGDON

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Bronchopneumonia	Few
DUE TO (b)	Arteriosclerosis	Yrs
DUE TO (c)	Hypertension	Yrs

444X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

0

21. I certify that (I) (this hospital) attended the deceased from Jan 12, 19 66 to Feb 1, 19 66, that (I) (we) last saw the deceased alive on Jan 28 19 66, and that death occured at 2:05 M, from the causes and on the date stated above.

22a. SIGNATURE: M. F. Martin M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): M N MARTIN

22d. ADDRESS: Westminster Md.

1

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 2-4-66

23c. NAME OF CEMETERY OR CREMATORY: LINTHICUM CHAPEL

23d. LOCATION (City, town or county) (State): CLARKSVILLE, Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: F.C. HIGINBOTHOM, ELLICOTT CITY Md

25a. REC'D BY REGISTRAR DATE: FEB 7 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
1SM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02156

CERTIFICATE OF DEATH

02107

1. PLACE OF DEATH
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Baltimore City
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 30-4
   d. STREET ADDRESS: 600 Willow Avenue
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle THOMAS Last GORDON

4. DATE OF DEATH: Month February Day 4 Year 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8-25-1875

9. AGE (In years last birthday): 90 yrs.
   IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Factory Worker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): England

12. CITIZEN OF WHAT COUNTRY? Naturalized U.S.A.

13. FATHER'S NAME: William Gordon

14. MOTHER'S MAIDEN NAME: Ann ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Unk. (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 213-10-1790

17. INFORMANT: Records, Springfield State Hospital — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease with congestive failure — INTERVAL BETWEEN ONSET AND DEATH: Years

4200

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8-24-65, 19, 8:30 A.M. to 2-4-66, 19, that (I) (we) last saw the deceased alive on 2-4-66 19, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE: Dr. Antonius Glahn M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 2-4-66

22c. PHYSICIAN'S NAME (Type): Antonius Glahn, M.D.

22d. ADDRESS: Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/8/66

23c. NAME OF CEMETERY OR CREMATORY: Cathedral Cemetery

23d. LOCATION (City, town or county) (State): Baltimore Md

24. FUNERAL DIRECTOR: Grand H Leary — ADDRESS: 814 436th St.

25a. REC'D BY REGISTRAR DATE: FEB 7 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02157

CERTIFICATE OF DEATH

02108

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Woodbine Md
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Woodbine Estates Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 21215
d. STREET ADDRESS: 3226 W. Garrison Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Edith — Middle: — Last: Gorsuch

4. DATE OF DEATH: Month: Feb — Day: 22 — Year: 1966

5. SEX: F

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 12/1/1882

9. AGE (In years last birthday): 83 yrs.

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Hecht Dept. Store

11. BIRTHPLACE (County & State, or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Lyon Mallone

14. MOTHER'S MAIDEN NAME: Hannah Matilda Emich

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 212-09-9195

17. INFORMANT: R. LeRoy Gorsuch Address: 411 Milford Mill Rd. Pikesville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary Occlusion	1 hr
DUE TO (b)	Chr. Hypertension	?
DUE TO (c)	Gen. Arterio Sclerosis	?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 15, 1966, to Feb 22, 1966, that (I) (we) last saw the deceased alive on Feb 20 1966, and that death occurred at 8 A.M., from the causes and on the date stated above.

22a. SIGNATURE: W. H. Martin — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Feb 22-66

22c. PHYSICIAN'S NAME (Type): W H MARTIN

22d. ADDRESS: Westminster Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/25/66

23c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery

23d. LOCATION (City, town or county) (State): Baltimore, Md.

24. FUNERAL DIRECTOR ADDRESS: Loring Byers-8728 Liberty Rd. Randallstown, Md.

25a. REC'D BY REGISTRAR DATE: FEB 28 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02158 — 02109

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1 month
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Owings Mills
d. STREET ADDRESS: 17 Walk Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LAURA — Middle BELL — Last GUNTER
4. DATE OF DEATH: Month February — Day 24 — Year 19 66
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-8-03
9. AGE (In years last birthday): 63 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Oklahoma
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: H. B. Arterberry
14. MOTHER'S MAIDEN NAME: Mandy Hildeberry
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT — Address: Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Septicemia — INTERVAL BETWEEN ONSET AND DEATH: Simultaneously
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Infected decubitus ulcers — 3 wks
DUE TO (c): Diabetes mellitus 20 yrs + Primary Infection days — 20 yrs
9040
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis + Chronic Brain Syndrome
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Fell at Home of Daughter
20c. TIME OF INJURY Month, Day, Year: 1-15-1966 — Hour a.m. p.m.
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Daughters Home
20f. (City or town) Salisbury (County) (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: W. Glenn Speicher — M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): W. Glenn Speicher, M.D.
Address (Street, town, or county): 13 S. Main St. Westminster Carroll Md. (State)
22. DATE SIGNED: 2-24-66

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2-26-66
23c. NAME OF CEMETERY OR CREMATORY: Evergreen Memorial Gardens
23d. LOCATION (City, town or county) (State): Finksburg, Md.

24. FUNERAL DIRECTOR — ADDRESS: J. F. Eline & Sons, Reisterstown, Md.
25a. REC'D BY REGISTRAR — DATE: FEB 28 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME (5)
5M 1/65

1

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02159

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02110

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
c. LENGTH OF STAY IN 1b: 5 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): near Gist Road

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster 06-1
d. STREET ADDRESS: 225 Smith Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RANDY — Middle WALTER — Last HALL

4. DATE OF DEATH: Month February — Day 23 — Year 1966

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 13, 1960

9. AGE (In years last birthday): 5 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): --

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (State or foreign country): Gettysburh, Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: A. Richard Hall

14. MOTHER'S MAIDEN NAME: Charlene Halm

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): --
(If yes give war or dates of service): --

16. SOCIAL SECURITY NO.: --

17. INFORMANT: A. Richard Hall — Address: same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Suffocation
DUE TO (b): Suffocating
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Sudden

9290

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Fell through Hole in ice on County Home Farm Pond

20c. TIME OF INJURY Month, Day, Year: Hour 1:30 a.m. p.m. 2-23 1966

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): County Farm

20f. (City or town) (County) (State): Westminster Carroll Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Wylen Speicher M.D.

EXAMINER'S NAME (Type)

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): 135 Ellerslie Westminster Carroll Md

22. DATE SIGNED: 2-23-66

23a. BURIAL, CREMATION, REMOVAL (Specify): burial

23b. DATE THEREOF: 2/26/66

23c. NAME OF CEMETERY OR CREMATORY: Meadow Branch Cemetery

23d. LOCATION (City, town or county) (State): nr Westminster Md.

24. FUNERAL DIRECTOR — ADDRESS: J. E. Myers, Jr., Westminster, Md.

25a. REC'D BY REGISTRAR DATE: FEB 28 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02160 02111

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville
c. LENGTH OF STAY IN 1b 0y 0m 23d
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Maryland 21530 b. COUNTY Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Flintstone
d. STREET ADDRESS ---- unknown
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First MAURICE Middle Woodward Last Hartsock
4. DATE OF DEATH Month 2 Day 8 Year 1966
5. SEX male
6. COLOR OR RACE white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 4-11-00
9. AGE (In years last birthday) 65 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bulldozer operator
10b. KIND OF BUSINESS OR INDUSTRY ----
11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Ensley Hartsock
14. MOTHER'S MAIDEN NAME Clara Willison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) no (If yes give war or dates of service) --
16. SOCIAL SECURITY NO. 211-05-5776
17. INFORMANT Hospital Records Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) **Congestive Heart failure** — INTERVAL BETWEEN ONSET AND DEATH: weeks
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) **Infarctive myocardial fibrosis with adhesive pericardium** — unknown
DUE TO (c) **Arteriosclerotic heart disease** — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
Chronic brain syndrome due to **cerebral arteriosclerosis** with psychotic reaction.
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ----
2Dc. TIME OF INJURY Month, Day, Year Hour a.m. p.m. ---- 19
2Dd. INJURY OCCURRED While at work ☐ Not While at Work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) --
20f. (City or town) (County) (State) --

21. I certify that (I) (this hospital) attended the deceased from 1-15, 1966, to 2-8, 1966, that (I) (we) last saw the deceased alive on 2-8 1966, and that death occurred at 12:15 a.m. from the causes and on the date stated above.

22a. SIGNATURE Heinz H. Klaatsch M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED 2-8-66
22c. PHYSICIAN'S NAME (Type) Heinz H. Klaatsch, M.D.
22d. ADDRESS Springfield State Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 2/10/66
23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park
23d. LOCATION (City, town or county) (State) Cumberland Rt3 Maryland

24. FUNERAL DIRECTOR ADDRESS Ruth E. Silcox Cumberland Maryland 21502
25a. REC'D BY REGISTRAR DATE FEB 14 1966
25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02161

CERTIFICATE OF DEATH

02112

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): New Windsor
   c. LENGTH OF STAY IN 1b: years
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Church Street

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Carroll
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): New Windsor
   d. STREET ADDRESS: Church Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EDGAR Middle CLARKSON Last HOUGH

4. DATE OF DEATH: Month February Day 3 Year 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 22, 1879

9. AGE (in years last birthday): 86 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer

10b. KIND OF BUSINESS OR INDUSTRY: own farm

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Warwick C. Hough

14. MOTHER'S MAIDEN NAME: Susanna Farquhar

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): None

16. SOCIAL SECURITY NO.: None

17. INFORMANT: William C. Hough — Address: Frederick Rural-Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Arteriosclerotic C.V.D.	years
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b)	Epithelioma - nose	years
DUE TO (c)		

4221

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 10, 1944, to 2/3/66, 19___, that (I) ~~did~~ last saw the deceased alive on 2/1/66 19___, and that death occurred at 2:45 P.M., from the causes and on the date stated above.

22a. SIGNATURE: M.E. Robertson — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/3/66

22c. PHYSICIAN'S NAME (Type): M. E. Robertson

22d. ADDRESS: New Windsor, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/6/66

23c. NAME OF CEMETERY OR CREMATORY: Quaker Cemetery

23d. LOCATION (City, town or county) (State): Union Bridge Maryland

24. FUNERAL DIRECTOR — ADDRESS: D.D. Hartzler & Sons, New Windsor

25a. REC'D BY REGISTRAR DATE: FEB 8 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02162 02113

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): Middleburg
c. LENGTH OF STAY IN 1b: 5 Days
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Brookfield Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give nearest town): Rural, Westminster
d. STREET ADDRESS: Westminster, Md. R. D. 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Martha — Middle L. — Last Humbert
4. DATE OF DEATH: Month February — Day 16 — Year 19 66

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5/26/1894
9. AGE (In years lost birthday): 71 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife-Housework
10b. KIND OF BUSINESS OR INDUSTRY: Her own Home.
11. BIRTHPLACE (State or foreign country): Carroll County, Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John W. B. Flickinger
14. MOTHER'S MAIDEN NAME: May Yeiser

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: John W. Humbert, Westminster, Md. R. D. 2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), ond (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)	Uremia	4 days
446 X — DUE TO (b)	Hypertension	2 or 3 yrs
Conditions, if ony, which gave rise to immediate couse (o), stoting the underlying couse lost. DUE TO (c)	Nephrosclerosis	2 or 3 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Dangrene of lower leg due to Arteriosclerosis; Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT (WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. — Month, Doy, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 16, 1966, to Feb 16, 1966, that (I) (we) last saw the deceased alive on Feb 16 1966, and that death occurred at 8 P. M, from the causes and on the date stated above.

22a. SIGNATURE: Julius Chepko M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2/17/66
22c. PHYSICIAN'S NAME (Type): Julius Chepko
22d. ADDRESS: 85½ W. Green St Westminster, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/19/66
23c. NAME OF CEMETERY OR CREMATORY: St. Marys Cemetery
23d. LOCATION (City, town, or county) (State): Silver Run, Carroll Co., Md.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Richard A. Little, Littlestown, PA.
25a. REC'D BY REGISTRAR DATE: FEB 18 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02163

CERTIFICATE OF DEATH

02114

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: CARROLL — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): UNION BRIDGE RURAL
   c. LENGTH OF STAY IN 1b: YEARS
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): MIDDLEBURG

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: CARROLL
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UNION BRIDGE RURAL 06-1
   d. STREET ADDRESS: MIDDLEBURG
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RAYMOND Middle ROBERT Last JOHNSON

4. DATE OF DEATH: Month FEB Day 21 Year 1966

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: SEPT 17 - 1891

9. AGE (In years last birthday): 74 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY: OWN FARM

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: GEORGE JOHNSON

14. MOTHER'S MAIDEN NAME: MARGARET GROFT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO
   (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 214-34-4564

17. INFORMANT: NELLIE JOHNSON Address: UNION BRIDGE RURAL MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro-vascular accident — INTERVAL BETWEEN ONSET AND DEATH: less than 1 hour
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cerebrovascular atherosclerosis.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypertensive cardiovascular disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8/30, 1959, to Feb 21, 1966, that (I) (we) last saw the deceased alive on Feb 18 1966, and that death occurred at 9 A M, from the causes and on the date stated above.

22a. SIGNATURE: A. Caricofe — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Feb 21, 1966

22c. PHYSICIAN'S NAME (Type): J H CARICOFE

22d. ADDRESS: UNION BRIDGE MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 2/24/66

23c. NAME OF CEMETERY OR CREMATORY: HAUGHS

23d. LOCATION (City, town or county) (State): LADIESBURG MD

24. FUNERAL DIRECTOR: D D Hartzler & Sons ADDRESS: Union Bridge, Md

25a. REC'D BY REGISTRAR DATE: FEB 23 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
20M 1/65

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02164

CERTIFICATE OF DEATH

02115

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by items 1 and 2 director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Carroll
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural - Sykesville
   c. LENGTH OF STAY IN 1b: 11m, 4d.
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Baltimore
   c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Baltimore
   d. STREET ADDRESS: 419 ORIOLE AVENUE 21228 ~~2926 Hanford Road~~
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Mary	Agnes	Jones	Feb.	19	1966

5. SEX	6. COLOR OR RACE	7. MARITAL STATUS	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9-17-~~84~~ 83	82 ~~84~~ yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	-- --	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
~~Frank Jones~~ THOMAS QUADE	~~Frances Lacey~~ HARRIET LACEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No - - -	None	MRS. NETTIE NEVAKER, 2046 WHISTLER AVENUE Springfield Hospital records, Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIAC FAILURE
DUE TO (b): CVA
DUE TO (c): A.C.V.H.D.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: DAYS / MONTH / YRS.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): CBS associated with senile brain with psychotic reaction

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Mar., 15, 1965, to Feb., 19, 1966, that (I) (~~We~~) last saw the deceased alive on Feb., 19 1966, and that death occurred at 1:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Mae L Boyd Jr M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: Feb. 19 1966
22c. PHYSICIAN'S NAME (Type): MAE L BOYD JR
22d. ADDRESS: Springfield State Hospital Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
BURIAL	2/22/66	LOUDON PARK CEMETERY	BALTIMORE, MARYLAND

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
HUBBARD FUNERAL HOME. 4107 WILKENS AVE. 21229	FEB 23 1966	J Charles Judge

VR A15 (4)
2DM 1/65

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02165

CERTIFICATE OF DEATH

02116

1. PLACE OF DEATH
a. COUNTY: Carroll
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 25 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 5005 Liberty Heights Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FANNIE Middle (NMN) Last KAMANITZ

4. DATE OF DEATH: Month FEBRUARY Day 13 Year 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Unk.

9. AGE (In years last birthday): 58? 59 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Simon Kamanitz

14. MOTHER'S MAIDEN NAME: Goldie (last name unk.)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: Unk.

17. INFORMANT: Records, Springfield State Hospital
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Nephrosclerosis — Interval between onset and death: Years

446X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Bronchopneumonia — Days

DUE TO (c): Generalized arteriosclerosis — Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-18-66, 19__, to 2-13-66, 19__, that (I) (we) last saw the deceased alive on 2-13-66 19__, and that death occurred at 8:00 PM, from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo. M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 2-14-66

22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M. D.

22d. ADDRESS: Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 2/14/1966

23c. NAME OF CEMETERY OR CREMATORY: BNAI ISRAEL

23d. LOCATION (City, town or county) (State): BALTO MD

24. FUNERAL DIRECTOR: SYLVAN S LEWIS SON ADDRESS: 3319 OLYMPIA AVE

25a. REC'D BY REGISTRAR DATE: FEB 15 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02166 02117

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural--Sykesville
c. LENGTH OF STAY IN 1b: 11 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 919 W. 38th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Pearl; Middle: Linder; Last: Kelly

4. DATE OF DEATH: Month: 2; Day: 1; Year: 1966

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 7/11/86

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Byron

14. MOTHER'S MAIDEN NAME: Sennett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT Address: Springfield Hospital records--Sykesville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — Interval between onset and death: Years
4200
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): Acute pulmonary artery infarction — Minutes
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year / Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from 3/1/ 1965 to 2/1/ 1966, that ☒ (we) last saw the deceased alive on 1/31/ 1966, and that death occurred at 12:02 a.m. from the causes and on the date stated above.

22a. SIGNATURE: Naci Nejat Buyukunsal

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 2/1/66

22c. PHYSICIAN'S NAME (Type): Naci Nejat Buyukunsal, M.D.

22d. ADDRESS: Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Jan.3,1966

23c. NAME OF CEMETERY OR CREMATORY: Baltimore National

23d. LOCATION (City, town or county) (State): Baltimore Maryland

24. FUNERAL DIRECTOR: Wm. Cook-Brooks, Inc.

ADDRESS: 1217 St. Paul Street

25a. REC'D BY REGISTRAR DATE: FEB 7 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02167

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02118

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): WESTMINISTER
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): CARROLL COUNTY GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminister
d. STREET ADDRESS: 132½ Penn Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

60

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
DEBBIE	LYNN	KINSER	2	6	1966

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White		March 10, 1965		10	

I

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Gettysburg, Penna.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Walter Wayne Kinser	Elizabeth Osborne

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
		Mrs. Elizabeth Osborne Kinser	same

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hydrocephalus — INTERVAL BETWEEN ONSET AND DEATH:
3441
DUE TO
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: R R Fisher M.D.
CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: 2-7-66

EXAMINER'S NAME (Type): RUSSELL S. FISHER, M.D.
Address (Street, city, town, or county):

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country) (State)
burial	2/9/66	Sandymount Cemetery	Finksburg RD 1, Maryland

23. FUNERAL DIRECTOR ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
J. E. Myers, Jr. Westminster, Md.	FEB 9 1966	J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02168

CERTIFICATE OF DEATH

02119

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural--Sykesville
c. LENGTH OF STAY IN 1b: 2mo. 29days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Woodbine
d. STREET ADDRESS: Route #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐?

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	Lillie	Gertrude	Leatherwood		2	7	1966

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
female	white		1/25/~~18~~ 80	~~86~~ 86 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
factory worker		Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Fowble	Shoemaker (Annie)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
no	none known	Springfield Hosp. records, Sykesville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bladder metastasis from CA of breast — INTERVAL BETWEEN ONSET AND DEATH: years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Generalized carcinomatosa — months
DUE TO (c):

170X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic brain syndrome with cerebral arteriosclerosis without qualifying phrase.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from 11/8/, 1965 to 2/7/, 1966, that ☒ (we) last saw the deceased alive on 2/7/ 1966, and that death occurred at 10:50 p.m. from the causes and on the date stated above.

22a. SIGNATURE	M.D.	ATTENDING PHYS. ☐	MED. DIRECTOR ☐	STAFF PHYS. ☒	22b. DATE SIGNED
Naci Nejat Buyukunsal					2/8/66

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
Naci Nejat Buyukunsal, M.D.	Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Soecify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	2/11/66	Morgan Chapel Cemetery	Carroll Co. Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
C.M.Waltz Box 241 Sykesville, Md.	FEB 11 1966	Charles Judge

VR A15 (4)
20M 1/65

Item 18, Film 381, 10/15/66 as

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02169 — 02120

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 38yrs.2mos.5dys.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1951 Edmondson Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

30-4

3. NAME OF DECEASED (Type or print): First JOHN — Middle J. — Last McCAFFREY

4. DATE OF DEATH: Month FEBRUARY — Day 28 — Year 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-28-1898

9. AGE (In years last birthday): 67 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stenographer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Patrick McCaffrey

14. MOTHER'S MAIDEN NAME: Mary Connelly

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Address: Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Terminal uremia
180X
DUE TO (b): ~~Left~~ renal carcinoma and ~~right~~ Left hydronephrosis
Right
DUE TO (c):

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Schizophrenic reaction, paranoid type — Acute dilatation urinary bladder

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12-23-27, 19 12:30 AM to 2-28-66, 19 ___, that (I) (we) last saw the deceased alive on 2-28-66, 19 ___, and that death occurred at ___ M, from the causes and on the date stated above.

22a. SIGNATURE: Octavio A Ruiz — M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 2-28-66

22c. PHYSICIAN'S NAME (Type): Octavio A.Ruiz, M. D.

22d. ADDRESS: Springfield State Hospital, Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/3/1966

23c. NAME OF CEMETERY OR CREMATORY: New Cathedral

23d. LOCATION (City, town or county) (State): Baltimore, Md.

24. FUNERAL DIRECTOR: Wm. J. Dickman & Sons

ADDRESS: Balto., Md. North 1-Pa.

25a. REC'D BY REGISTRAR: DATE MAR 1 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02170

CERTIFICATE OF DEATH

02121

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: CARROLL
MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): SYKESVILLE
c. LENGTH OF STAY IN 1b: 9 WEEKS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): PULLEN NURSING HOME

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NEW WINDSOR
d. STREET ADDRESS: CHURCH ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Irene Middle: N Last: McClelland

4. DATE OF DEATH: Month: FEB Day: 5 Year: 1966

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: OCT 6 - 1891

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEKEEPER

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: REUBEN GRIMES

14. MOTHER'S MAIDEN NAME: MARY JANE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: WM McCLELLAND Address: WESTMINSTER MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis, Cardiac failure, — INTERVAL BETWEEN ONSET AND DEATH: 10-31-65
H201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerosis generalized, Ca of — 2-5-66
DUE TO (c): Lung

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10-31-, 1965, to 2-5, 1966, that (I) (we) last saw the deceased alive on 2-5- 1966, and that death occurred at 6:30 PM, from the causes and on the date stated above.

22a. SIGNATURE: Howard E. Hall M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): HOWARD E HALL

22d. ADDRESS: Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: FEB 8, 1966

23c. NAME OF CEMETERY OR CREMATORY: BETHEL

23d. LOCATION (City, town or county) (State): CARROLL CO MD

24. FUNERAL DIRECTOR: D D Hartzler & Sons ADDRESS: New Windsor, Md

25a. REC'D BY REGISTRAR DATE: FEB 8 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02171 Item #6 Film #G373 2/21/66 pc

CERTIFICATE OF DEATH

02122

1. PLACE OF DEATH
   a. COUNTY: Carroll
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural--Sykesville
   c. LENGTH OF STAY IN 1b: 43y. 3m. 22d.
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Allegany ✓
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
   d. STREET ADDRESS: unknown
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

01-2

12

3. NAME OF DECEASED (Type or print): First: Margaret; Middle: ; Last: McSorley

4. DATE OF DEATH: Month: 2; Day: 7; Year: 1966

5. SEX: female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: unknown

9. AGE (In years last birthday): 81? yrs.

IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

I

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ~~unknown~~ George Krieglein

14. MOTHER'S MAIDEN NAME: ~~unknown~~ Anna Britton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Springfield Hospital records, Sykesville (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 5 days

4200

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic heart disease — Years

DUE TO (c): General arteriosclerosis — Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Schizophrenic reaction, chronic undifferentiated type.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (☒ this hospital) attended the deceased from 10/15/, 1922, to 2/7/, 1966, that (☐ we) last saw the deceased alive on 2/7/ 1966, and that death occurred at 2A.M., from the causes and on the date stated above.

22a. SIGNATURE: Frances Reid Nabors, M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 2/7/66

22c. PHYSICIAN'S NAME (Type): Frances Reid Nabors, M. D.

22d. ADDRESS: Springfield State Hospital Sykesville, Maryland

1

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/11/66

23c. NAME OF CEMETERY OR CREMATORY: St. Peter & Paul Cem.

23d. LOCATION (City, town or county) (State): Cumberland, Md

24. FUNERAL DIRECTOR: Louis Stein Inc. ADDRESS: Cumb. Md.

25a. REC'D BY REGISTRAR DATE: FEB 11 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M 1/65

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02178

CERTIFICATE OF DEATH

02123

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: CARROLL — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): SYKESVILLE
   c. LENGTH OF STAY IN 1b: 1YR. 4mos, 11 da.
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): SPRINGFIELD STATE HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: CARROLL
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLD FORT ROAD, MANCHESTER
   d. STREET ADDRESS: OLD FORT ROAD, ROUTE #1
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First GEORGE — Middle HENRY — Last MEYERS

4. DATE OF DEATH: Month FEBRUARY — Day 23 — Year 1966

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: 8-16-1887

9. AGE (in years last birthday): 78 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: WILLIAM H. MEYERS

14. MOTHER'S MAIDEN NAME: SARAH E. HUDSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
    (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT — Address: RECORDS, SPRINGFIELD STATE HOSPITAL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Cardiac Failure
4221
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Cardiovascular Disease
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: DAYS / YEARS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Bronchopneumonia

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10-12-64, 19__, to 2-23-66, 19__, that (I) (we) last saw the deceased alive on FEB. 23 1966, and that death occurred at 7:50 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Robert M. Deeb M.D. — ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]

22b. DATE SIGNED: 2-23-66

22c. PHYSICIAN'S NAME (Type): ROBERT M. DEEB, M.D

22d. ADDRESS: SPRINGFIELD STATE HOSPITAL, SYKESVILLE, MD 21784.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/26/66

23c. NAME OF CEMETERY OR CREMATORY: Manchester

23d. LOCATION (City, town or county) (State): Manchester Md.

24. FUNERAL DIRECTOR — ADDRESS: Tipton-Eline, Hampstead, Md.

25a. REC'D BY REGISTRAR DATE: MAR 1 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02173

CERTIFICATE OF DEATH

02124

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 5mos.5dys.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street eddress): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 4501 Courtland Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALWINE — Middle (NMN) — Last MILLER

4. DATE OF DEATH: Month FEBRUARY — Day 6 — Year 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4-2-1884

9. AGE (In years last birthday): 81 yrs. — IF UNDER 1 YEAR: Months 10, Days 4 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Gobel

14. MOTHER'S MAIDEN NAME: Lena Nass

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 106-36-7463

17. INFORMANT Address: Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), end (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Shock — INTERVAL BETWEEN ONSET AND DEATH: ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Rupture of left ovarian cyst — ?
DUE TO (c):

216 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic cardiovascular disease.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9-1-65, 19__, to 2-6-66, 19__, that (I) (we) last saw the deceased alive on 2-6-66 19__, and that death occurred at 8:45 PM, from the causes and on the date stated above.

22a. SIGNATURE: Frances Reid Nabors, M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 2/6/66

22c. PHYSICIAN'S NAME (Type): Frances Reid Nabors, M. D.

22d. ADDRESS: Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/9/66

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

23d. LOCATION (City, town or county) (State): Suitland, Md.

24. FUNERAL DIRECTOR: Robert A. Pumphrey ADDRESS: Bethesda, Md.

25a. REC'D BY REGISTRAR DATE: FEB 10 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02174 02125

1. PLACE OF DEATH
a. COUNTY: CARROLL MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): NEW WINDSOR RURAL
c. LENGTH OF STAY IN 1b: 6 WEEKS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): HORTONS BOARDING HOME

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UNION BRIDGE 06-1
d. STREET ADDRESS: ELGAR ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARIA Middle FRANCES Last MILLER
4. DATE OF DEATH: Month FEB. Day 15 Year 1966
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MAY 11 - 1880
9. AGE (In years last birthday): 85 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEKEEPER
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: CHARLES STITELY
14. MOTHER'S MAIDEN NAME: MARTHA WELTY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: MARIAN AUSTIN Address: DETOUR MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 24 Hrs.
4221
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): arteriosclerotic CVD — years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/22/65, 19__, to 2/15/66 19__, that (I) ~~last~~ saw the deceased alive on 2/15/66 19__, and that death occurred at 8 ~~P~~ A.M., from the causes and on the date stated above.

22a. SIGNATURE: M.E. Robertson M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2/15/66
22c. PHYSICIAN'S NAME (Type): M.E. ROBERTSON
22d. ADDRESS: New Windsor, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 2-17-66
23c. NAME OF CEMETERY OR CREMATORY: UNION CEM.
23d. LOCATION (City, town or county) (State): KEYSVILLE MD.
24. FUNERAL DIRECTOR: D.D. Hartle & Sons ADDRESS: UNION BRIDGE MD.
25a. REC'D BY REGISTRAR DATE: FEB 17 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02175 02126

1. **PLACE OF DEATH**
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Manchester
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 15 South Main Street

2. **USUAL RESIDENCE** (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland b. COUNTY: Carroll
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Manchester Maryland 06-1
d. STREET ADDRESS: 15 South Main street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Wesley Middle: Caleb Last: Miller

4. **DATE OF DEATH**: Month: February Day: 27 Year: 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 24, 1881

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (County & State, or foreign country): Miller, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Miller

14. MOTHER'S MAIDEN NAME: Mollie Harris

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no

16. SOCIAL SECURITY NO.: 220-34-5911

17. INFORMANT: Mrs Cora V. Miller Address: Manchester Md.

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Myocarditis
DUE TO (b): Arteriosclerotic Cardio Vascular Renal
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bronchial Asthma

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 10, 1956 to February 27, 1966 that (I) (we) last saw the deceased alive on February 25 1966 and that death occured 2:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Joseph E Bush M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2/27/66

22c. PHYSICIAN'S NAME (Type): Joseph E Bush MD

22d. ADDRESS: Hampstead Maryland.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/2/66
23c. NAME OF CEMETERY OR CREMATORY: Greenmount
23d. LOCATION (City, town or county) (State): Carroll Co. Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Tipton-Eline
ADDRESS: Hampstead, Md.

25a. REC'D BY REGISTRAR DATE: MAR 3 1966
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02176

CERTIFICATE OF DEATH

02127

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Manchester
c. LENGTH OF STAY IN 1b: about 6 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Died at office Dr. W H Foard

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hampstead, Md. 06-1
d. STREET ADDRESS: Fairmount Road
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Gordon — Middle: (GORDON OLER) — Last: Oler
4. DATE OF DEATH: Month: Feb — Day: 14 — Year: 1966
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: July 23 - 1908
9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plumber
10b. KIND OF BUSINESS OR INDUSTRY: Plumbing
11. BIRTHPLACE (County & State, or foreign country): Baltimore, Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John W. Oler
14. MOTHER'S MAIDEN NAME: Anna A. Arndt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no
(If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 213-10-5737
17. INFORMANT: Mrs Helen Lippy — Address: Hampstead 2 Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1/2 hour
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Cardio Vascular Renal — 2 yrs
DUE TO (c):
420

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug, 1959, to Feb 14, 1966, that (I) (we) last saw the deceased alive on 2/14 1966, and that death occurred at 12:15 P.M., from the causes and on the date stated above.

22a. SIGNATURE: W H Foard M.D. — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 2/14/66
22c. PHYSICIAN'S NAME (Type): W. H. FOARD M.D.
22d. ADDRESS: Manchester, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/17/66
23c. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cemetery
23d. LOCATION (City, town or county) (State): Pikesville, Balto. Co. Md.

24. FUNERAL DIRECTOR: C. Vernon Simmons — ADDRESS: 4611 Park Heights Av. Balto.
25a. REC'D BY REGISTRAR — DATE: FEB 16 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

Burial 2/17/66 Druid Ridge Cemetery Pikesville, Balto. Co. Md.

4611 Park Heights Av. Balto.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02177 02128

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1yr.7mos.18dys.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Poolesville
d. STREET ADDRESS: Box 17, Cat Tail Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SOLOMON — Middle (NMN) — Last OWENS

4. DATE OF DEATH: Month FEBRUARY — Day 3 — Year 1966

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 6-8-1873

9. AGE (In years last birthday): 92 yrs. — IF UNDER 1 YEAR: Months — IF UNDER 24 HRS.: Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Hessen Owens

14. MOTHER'S MAIDEN NAME: Mary Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 214-18-8235

17. INFORMANT — Address: Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic heart disease with failure — INTERVAL BETWEEN ONSET AND DEATH: yrs.-dys.

4200

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
OUE TO (b):
OUE TO (c): Terminal bronchopneumonia — days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): CBS assoc. with senile brain disease, with psychotic reaction

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6-15-64, 19__ to 2-3-66, 19__, that (I) (we) last saw the deceased alive on 2-3-66 19__, and that death occurred at 10:15 AM, from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo. — M.O. ATTENOING PHYS. ☐ MEO. DIRECTOR ☐ STAFF PHYS. ☒ — 22b. OATE SIGNEO: 2-3-66

22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M. D.

22d. AODRESS: Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 23b. DATE THEREOF: 2/8/66 — 23c. NAME OF CEMETERY OR CREMATORY: Elizah Church Cem. — 23d. LOCATION (City, town or county) (State): Poolesville, Md.

24. FUNERAL DIRECTOR: George R. Brandau — ADDRESS: Rockville, Md.

25a. REC'D BY REGISTRAR DATE: FEB 8 1966 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02178 02129

1. PLACE OF DEATH
a. COUNTY: Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural--Sykesville
c. LENGTH OF STAY IN 1b: 1y. 7m. 19d.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1306 E. 33rd Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elmyra Middle: Jane Last: Peters
4. DATE OF DEATH: Month: 2 Day: 11 Year: 1966
5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 8/20/80
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Jonathan Geddling
14. MOTHER'S MAIDEN NAME: Margaret Reese
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT Address: Springfield Hospital records, Sykesville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: days
493 f
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Pneumonia — days
DUE TO (c): Respiratory acidosis and uremia — days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e): Chronic brain syndrome with senile brain disease without qualifying phrase.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (☒ (this hospital) attended the deceased from 6/22/ , 1964, to 2/11/ , 1966, that ☒ (we) last saw the deceased alive on 2/11/ 1966, and that death occurred at 6:30 a.m., from the causes and on the date stated above.

22a. SIGNATURE: R. G. Lajonchere M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 2/11/66
22c. PHYSICIAN'S NAME (Type): Rinaldo G. Lajonchere, M.D.
22d. ADDRESS: Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE THEREOF: 2/14/1966
23c. NAME OF CEMETERY OR CREMATORY: Allen Union Cemetery
23d. LOCATION (City, town or county) (State): Northhampton, Pennsylvania
24. FUNERAL DIRECTOR: Wm. J. Kirkner & Sons — ADDRESS: Bath, Pa.
25a. REC'D BY REGISTRAR DATE: FEB 14 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02179

CERTIFICATE OF DEATH

02130

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Rural) Sykesville
c. LENGTH OF STAY IN MARYLAND: 1y 4m 4d
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland 21212
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City 30-4
d. STREET ADDRESS: 1016 St. Dunstan's Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Frederick; Middle Aloyious; Last Peters

4. DATE OF DEATH: Month 2; Day 9; Year 1966

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11-2-98

9. AGE (In years last birthday): 67 yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Wood work

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Michael Peters

14. MOTHER'S MAIDEN NAME: Mary Wetzelburger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): unknown (No)

16. SOCIAL SECURITY NO.: 219-14-0865

17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia, bilateral. — 491X — INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): ---

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. --- 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): --

20f. (City or town) (County) (State): --

21. I certify that (I) (this hospital) attended the deceased from 10-5- , 1964 to 2-9 , 1966 that (I) (we) last saw the deceased alive on 2-9- 1966 and that death occurred at 6:45 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Heinz H. Klaatsch M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 2-10-66

22c. PHYSICIAN'S NAME (Type): Heinz H. Klaatsch, M.D.

22d. ADDRESS: Springfield State Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 2/14/66.

23c. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cem.

23d. LOCATION (City, town or county) (State): Balto. Md.

24. FUNERAL DIRECTOR: LEONARD J. RUCK, INC. — ADDRESS: Balto. Md. 21214

25a. REC'D BY REGISTRAR DATE: FEB 15 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02180

CERTIFICATE OF DEATH

02131

1. PLACE OF DEATH
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
   c. LENGTH OF STAY IN 1b: 4yrs.3mos.24dys.
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Baltimore
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
   d. STREET ADDRESS: 7010 York Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

12

3. NAME OF DECEASED (Type or print): First FLORENCE — Middle AMELIA — Last REATHER

4. DATE OF DEATH: Month February — Day 18 — Year 19 66

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9-18-1877

9. AGE (In years last birthday): 88 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: H. Lange

14. MOTHER'S MAIDEN NAME: Caroline Weise

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
    (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT — Address: Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease. — INTERVAL BETWEEN ONSET AND DEATH: years

4200

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.

DUE TO (b): Terminal bronchopneumonia. — dys.

DUE TO (c): Generalized arteriosclerosis. — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic brain syndrome with senile brain disease, without qualifying phrase.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

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20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10-24-61, 19 to 2-18-66, 19, that (I) (we) last saw the deceased alive on 2-18-66 19, and that death occurred at 3:03 p.m., from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 2-18-66

22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M.D.

22d. ADDRESS: Springfield State Hospital, Sykesville, Maryland 21784

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: FEB. 24, 1966

23c. NAME OF CEMETERY OR CREMATORY: LOUDON PARK CEMETERY

23d. LOCATION (City, town or county) (State): BALTIMORE, MARYLAND

24. FUNERAL DIRECTOR — ADDRESS: John Burns' Sons, Towson, Md.

25a. REC'D BY REGISTRAR — DATE: FEB 23 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M 1/65

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02181 (02132)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville
   c. LENGTH OF STAY IN 1b: 5yrs.8mos.22dys.
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Montgomery
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Poolesville 15-2
   d. STREET ADDRESS: ----
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JESSIE — Middle (NMN) — Last RITCHEY

4. DATE OF DEATH: Month FEBRUARY — Day 1 — Year 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8-23-1873

9. AGE (In years last birthday): 92 yrs.
   IF UNDER 1 YEAR: Months ____ Days ____
   IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles [illegible] Elgin

14. MOTHER'S MAIDEN NAME: Helen Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
   (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 109-18-9833

17. INFORMANT: Address: Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: Years

4200

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Generalized arteriosclerosis — Years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): CBS associated with cerebral arteriosclerosis, with psychotic reaction

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-9-60, 19__ to 2-1-66, 19__, that (I) (we) last saw the deceased alive on 2-1-66 19__, and that death occurred at 11:25 AM, from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo. M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 2-1-66

22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M. D.

22d. ADDRESS: Springfield State Hospital, Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/5/66

23c. NAME OF CEMETERY OR CREMATORY: Monocacy

23d. LOCATION (City, town or county) (State): Beallsville, Maryland

24. FUNERAL DIRECTOR — ADDRESS: William B. Hilton, Barnesville Md

25a. REC'D BY REGISTRAR DATE: FEB 9 1966

25b. REGISTRAR'S SIGNATURE: [illegible] Judge

VR A15 (4)
20M 1/65

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02182 02133

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Westminster
c. LENGTH OF STAY IN 1b: 3½ HOURS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Carroll County General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL Westminster, Md. RT #6
d. STREET ADDRESS: Box 112
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY — Middle ELIZABETH — Last ROBERTSON
4. DATE OF DEATH: Month 2-8-66 — Day — Year 19

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: AUG. 5, 1914
9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SECRETARY
10b. KIND OF BUSINESS OR INDUSTRY: INSURANCE OFFICE
11. BIRTHPLACE (State or foreign country): BALTO. MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MARVIN T. RATCLIFF
14. MOTHER'S MAIDEN NAME: ELIZABETH VICK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO
(If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: 215-07-8568
17. INFORMANT: HUSBAND — Address: WILLIAM F. ROBERTSON BOX 112 RT #6 WESTMINSTER, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Multiple traumatic injuries
8161
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): auto-truck accident
20c. TIME OF INJURY Hour: 8:30 xxx e.m. — Month, Day, Year: 2-8 1966
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): road
20f. (City or town) (County) (State): Carroll

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐, and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: R Breitenecker M.D.
EXAMINER'S NAME (Type): Rudiger Breitenecker, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county):
DATE SIGNED: 2-9-66

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 2/12/66
22c. NAME OF CEMETERY OR CREMATORY: LAKE VIEW MEMORIAL
22d. LOCATION (City, town, or country) (State): LIBERTY ROAD NEAR ELDERSBURG MD.

23. FUNERAL DIRECTOR: James G. Saffell Jr. — ADDRESS 254 E. MAIN ST. WESTMINSTER, MD.
24a. REC'D BY REGISTRAR (Date): FEB 10 1966
24b. REGISTRAR'S SIGNATURE: J Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02183 02134

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville RD #2
c. LENGTH OF STAY IN 1b: 16 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Golden Age Guest Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
d. STREET ADDRESS: 48 Longwell Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CLARA — Middle — Last SCHAFFER

4. DATE OF DEATH: Month February — Day 21 — Year 1966

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 29, 1875

9. AGE (In years last birthday): 90 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Carroll County, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Philip J. Yost

14. MOTHER'S MAIDEN NAME: Mary C. Utz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): —
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Charles D. Schaffer — Address: 48 Longwell Ave Westminster, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Embolism — INTERVAL BETWEEN ONSET AND DEATH: Days

4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Chr Myocarditis — ?

DUE TO (c): Senile Arteriosclerosis — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb 5, 19 66, to Feb 21, 19 66, that (I) (we) last saw the deceased alive on Feb 21 19 66, and that death occurred at [illegible] M, from the causes and on the date stated above.

22a. SIGNATURE: M. A. Masten — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2-27-66

22c. PHYSICIAN'S NAME (Type): M. A. MASTEN

22d. ADDRESS: Westminster Md

23a. BURIAL, CREMATION, REMOVAL (Specify): burial

23b. DATE THEREOF: 2/24/66

23c. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cemetery

23d. LOCATION (City, town or county) (State): Pikesville, Maryland

24. FUNERAL DIRECTOR: J. E. Myers Jr. — ADDRESS: West minster, Md.

25a. REC'D BY REGISTRAR DATE: FEB 23 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02184

CERTIFICATE OF DEATH

02135

1. PLACE OF DEATH
a. COUNTY Carroll
MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville
c. LENGTH OF STAY IN 1b 0y 9m 17d
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Maryland b. COUNTY 21212 Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 03-2
d. STREET ADDRESS 515 Windwood Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Carl Middle A. Last Seward, Sr.
4. DATE OF DEATH Month 2 Day 11 Year 1966
5. SEX male
6. COLOR OR RACE white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 11-20-98
9. AGE (In years last birthday) 67 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photo engraver
10b. KIND OF BUSINESS OR INDUSTRY ---
11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME George Seward
14. MOTHER'S MAIDEN NAME Josephine Allen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) WWI
(If yes give war or dates of service) unknown
16. SOCIAL SECURITY NO. 215-01-0211
17. INFORMANT Hospital Records Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Abscesses — INTERVAL BETWEEN ONSET AND DEATH 10 days +
491X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Bilateral recurring bronchopneumonia — ?
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) --
20c. TIME OF INJURY Hour a.m. p.m. -- Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) -- (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-24, 1965, to 2-11, 1966, that (I) (we) last saw the deceased alive on 2-11 1966, and that death occurred 12:40 P.M. from the causes and on the date stated above.

22a. SIGNATURE Heinz H. Klaatsch M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED 2-11-66
22c. PHYSICIAN'S NAME (Type) Heinz H. Klaatsch, M.D.
22d. ADDRESS Springfield State Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 2/15/66.
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.
23d. LOCATION (City, town or county) (State) Arlington, Va.

24. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc. Balto. Md. 21214
25a. REC'D BY REGISTRAR DATE FEB 15 1966
25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02185 02136

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 45yrs.25dys.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: Unk. Trans. from Bay View Hospital
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LAWRENCE Middle (NMN) Last SIKORSKI
4. DATE OF DEATH: Month FEBRUARY Day 20 Year 1966
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ Unk.
8. DATE OF BIRTH: Unk.
9. AGE (In years last birthday): 81 ? yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (County & State, or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY? Alien ✓
13. FATHER'S NAME: Unk.
14. MOTHER'S MAIDEN NAME: Unk.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT Address: Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Lung abscess — INTERVAL BETWEEN ONSET AND DEATH: Days
521X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Schizophrenic reaction, hebephrenic type
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-25-21 19__, to 2-20-66, 19__, that (I) (we) last saw the deceased alive on 2-20-66 19__, and that death occurred at 10:15 AM, from the causes and on the date stated above.

22a. SIGNATURE: Octavio A Ruiz — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 2-21-66
22c. PHYSICIAN'S NAME (Type): Octavio A. Ruiz, M. D.
22d. ADDRESS: Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2-23-66
23c. NAME OF CEMETERY OR CREMATORY: New Cathedral
23d. LOCATION (City, town or county) (State): Baltimore, Md.
24. FUNERAL DIRECTOR: Luther H. Knight ADDRESS: Sykesville, Md.
25a. REC'D BY REGISTRAR DATE: FEB 25 1966
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02186 02137

1. **PLACE OF DEATH**
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural Manchester Md
c. LENGTH OF STAY IN 1b: 31 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Water Tank Road

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Manchester, Maryland
d. STREET ADDRESS: Water Tank Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: William — Middle: Edgar — Last: Smith

4. **DATE OF DEATH**: Month: February — Day: 25 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: February 20, 1894

9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: General

11. BIRTHPLACE (County & State, or foreign country): York Penna

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

16. SOCIAL SECURITY NO.: 215-09-7027

17. INFORMANT: Mrs Helen Smith — Address: Manchester Md

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Suddenly

DUE TO (b): Coronary Heart Disease — 4 yrs

DUE TO (c): Chronic Myocarditis — ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 1, 1960 to February 25, 1966 that (I) (we) last saw the deceased alive on 2-17, 19 66, and that death occured at 8 A.M, from the causes and on the date stated above.

22a. SIGNATURE: Joseph E Bush M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2-25-66

22c. PHYSICIAN'S NAME (Type): Joseph E. Bush MD

22d. ADDRESS: HAMPSTEAD Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: Feb 28/66 — 23c. NAME OF CEMETERY OR CREMATORY: Millers Cemetary — 23d. LOCATION (City, town or county) (State): Carroll Co Md

24. FUNERAL DIRECTOR'S SIGNATURE: Upton-Eline — ADDRESS: Hampstead Md

25a. RECD BY REGISTRAR DATE: MAR 1 1966 — 25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02187 02138

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. CDUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
c. LENGTH OF STAY IN 1b: 40 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 553 Baltimore Boulevard

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
d. STREET ADDRESS: 553 Baltol Boulevard
e. IS RESIDENCE DN A FARM? YES ☐ ND ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle HENRY Lest SMITH

4. DATE OF DEATH: Month Feb. Day 4, Year 1966

5. SEX: male

6. CDLDR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDDWED ☐ DIVORCED ☐

8. DATE DF BIRTH: July 19, 1888

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

1Da. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): meat cutter

1Db. KIND DF BUSINESS DR INDUSTRY: chain store

11. BIRTHPLACE (County & State, or foreign country): New Windsor RD

12. CITIZEN DF WHAT CDUNTRY? U.S.A.

13. FATHER'S NAME: James Smith

14. MOTHER'S MAIDEN NAME: Mollie Sleckbier

15. WAS DECEASED EVER IN U.S. ARMED FDRCES? (Yes, no, or unkown): --
(If yes give war or dates of service): --

16. SDCIAL SECURITY NO.: 214-01-0532

17. INFORMANT: Mrs. William H. Smith — Address: same

MEDICAL CERTIFICATION

18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cordis Vascular Failure
4500
Conditions, if eny, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TD (b): Generalized Atherosclerosis.
DUE TD (c):

INTERVAL BETWEEN DNSET AND DEATH

PART II. DTHER SIGNIFICANT CONDITIDNS CDNTRIBUTING TD DEATH BUT NOT RELATED TD THE TERMINAL DISEASE CDNDITION GIVEN IN PART 1(a)

19. WAS AUTDPSY PERFDRMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE DF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

2Dd. INJURY OCCURRED While at work ☐ Not While at work ☐

2De. PLACE DF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/ , 1964, to 2/4 , 1966, that (I) (we) last saw the deceased alive DN Jan 22 1966, and that death occurred at 3:55 PM, from the causes and on the date stated above.

22a. SIGNATURE: William R. O'Rourke M.D. ATTENDING PHYS. ☒ MED. DIRECTDR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/5/66.

22c. PHYSICIAN'S NAME (Type): William R O'Rourke

22d. ADDRESS: 150 W. Main St. Westminster.

23a. BURIAL, CREMATIDN, REMDVAL (Specify): burial

23b. DATE THEREDF: 2/7/66

23c. NAME DF CEMETERY DR CREMATDRY: Carrollton Church Cem.

23d. LDCATION (City, town or county) (State): Finksburg, RD Maryland

24. FUNERAL DIRECTOR: J. E. Myers, Jr. — ADDRESS: Westminster, Md.

25a. REC'D BY REGISTRAR DATE: FEB 7 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02188

CERTIFICATE OF DEATH

02139

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): SYKESville
c. LENGTH OF STAY IN 1b: 30 yrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): SPRINGFIELD STATE HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WASHINGTON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MAUGANSville 21-2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First LUCY Middle Irene Last SPICKLER

4. DATE OF DEATH: Month FEB Day 12 Year 1966

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: AUG 8, 1889

9. AGE (In years last birthday): 76 yrs.

IF UNDER 1 YEAR — Months: Days: IF UNDER 24 HRS. — Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Maugansville Washington Co MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MICHAEL LOWERY

14. MOTHER'S MAIDEN NAME: ANNABELLE EVERSOLE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Chester L. Spickler Address: 115 Union Ave Martinsburg W. Va

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart disease — INTERVAL BETWEEN ONSET AND DEATH: years
4200
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Generalized Arteriosclerosis — years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Adenocarcinoma of uterus & Schizophrenic Paranoid

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb. 9, 1966, to 2-12-, 1966 that (I) (we) last saw the deceased alive on Feb. 12 1966, and that death occurred at 11.50 A M, from the causes and on the date stated above.

22a. SIGNATURE: Agustin del Campo. MD — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑

22b. DATE SIGNED: 2-12-1966

22c. PHYSICIAN'S NAME (Type): AGUSTIN DEL CAMPO MD

22d. ADDRESS: SYKESVILLE MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2-15-66

23c. NAME OF CEMETERY OR CREMATORY: Dunkard Cemetery

23d. LOCATION (City, town or county) (State): Broadfording Wash Co Md

24. FUNERAL DIRECTOR: Hagerstown ADDRESS Md
ANDREW K. COFFMAN FUNERAL Home Inc

25a. REC'D BY REGISTRAR DATE: FEB 15 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02189

CERTIFICATE OF DEATH

02140

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): New Windsor Rural
   c. LENGTH OF STAY IN 1b: years
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rural

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Carroll
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): New Windsor Rural
   d. STREET ADDRESS: none
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: EDWARD — Middle: STEINBERG — Last: SR.

4. **DATE OF DEATH**: Month: February — Day: 18 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 23, 1885

9. AGE (In years last birthday): 80 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (County & State, or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Franc Steinberg

14. MOTHER'S MAIDEN NAME: Wilhemina Schultz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
    (If yes give war or dates of service): none

16. SOCIAL SECURITY NO.: 213-16-1661

17. INFORMANT: Mrs. Barbara Steinberg — Address: New Windsor Rural, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic C.V.D. — INTERVAL BETWEEN ONSET AND DEATH: years
4221
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2/11/66 19..., to 2/18 ..., 1966, that (I) (~~we~~) last saw the deceased alive on 2/14/66 19..., and that death occurred at 7:20 P.M., from the causes and on the date stated above.

22a. SIGNATURE: M. E. Robertson M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): M. E. Robertson

22d. ADDRESS: New Windsor, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/21/66

23c. NAME OF CEMETERY OR CREMATORY: Greenwoods Cemetery

23d. LOCATION (City, town or county) (State): New Windsor Rural Md

24 FUNERAL DIRECTOR'S SIGNATURE: D. D. Hartzler & Sons — ADDRESS: New Windsor, Md

25a. REC'D BY REGISTRAR DATE: FEB 21 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A1S (4)
20M 5-63

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02190 02141

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
   c. LENGTH OF STAY IN 1b: 2 days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Carroll County General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) — e. STATE: Maryland — b. COUNTY: Carroll
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): New Windsor Rural 06-1
   d. STREET ADDRESS: None
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ETHEL — Middle: Luella — Last: STRINE

4. DATE OF DEATH: Month: 2 — Day: 3 — Year: 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: October 22, 1891

9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Nathan Haines

14. MOTHER'S MAIDEN NAME: Dolly Carr

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
    (If yes give war or dates of service): None

16. SOCIAL SECURITY NO.: 220-44-1759

17. INFORMANT: Ralph W. Strine — Address: Union Bridge Rural-Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CONGESTIVE HEART FAILURE - INTRACTIBLE — INTERVAL BETWEEN ONSET AND DEATH: 1 WK

443 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): HYPERTENSIVE ARTERIOSCLEROTIC

~~DUE TO~~ (c): CARDIOVASCULAR DISEASE — YEARS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): BRONCHOPNEUMONIA

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/1, 1966, to 2/3, 1966, that (I) (we) last saw the deceased alive on 2/3 1966, and that death occurred at 7:35 M, from the causes and on the date stated above.

22a. SIGNATURE: Vincent J. Fiocco Jr. M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/3/66

22c. PHYSICIAN'S NAME (Type): Vincent J. Fiocco, Jr.

22d. ADDRESS: Westminster, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/6/66

23c. NAME OF CEMETERY OR CREMATORY: Sams Creek Cemetery

23d. LOCATION (City, town or county) (State): New Windsor Rural Md.

24. FUNERAL DIRECTOR: D. D. Hartzler & Sons — ADDRESS: New Windsor, Md.

25a. REC'D BY REGISTRAR DATE: FEB 8 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
2DM 1/65

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STRIKE

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02191

CERTIFICATE OF DEATH

02142

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): RURAL - Sykesville
c. LENGTH OF STAY IN 1b: 44Y. 11 Mo.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): SPRINGFIELD STATE HOSPITAL.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BALTO. 30-4
d. STREET ADDRESS: NONE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

12

3. NAME OF DECEASED (Type or print): First: SADIE — Middle: — Last: TALKIN

4. DATE OF DEATH: Month: 2 — Day: 12 — Year: 1966

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-5-99

9. AGE (In years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: NATHANIEL TALKIN

14. MOTHER'S MAIDEN NAME: Bessie DUNN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: SPRINGFIELD HOSP. RECORDS - SYKESVILLE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIAC FAILURE DUE TO — INTERVAL BETWEEN ONSET AND DEATH: HRS
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): ASCVD. CORONARY THROMBOSIS
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): SCHIZOPHRENIA - HEB.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3-23, 1921, to 2-12, 1966, that (I) (we) last saw the deceased alive on 2-12 1966, and that death occurred at 1:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Igor D. Buyukinsoy M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 2/13/66

22c. PHYSICIAN'S NAME (Type): NAZI NEJAT BUYUKINSOY M.D. — 22d. ADDRESS: SPRINGFIELD STATE HOSP.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 2/14/66 — 23c. NAME OF CEMETERY OR CREMATORY: Mt Lebanon — 23d. LOCATION (City, town or county) (State): Brooklyn New York

24. FUNERAL DIRECTOR: Sylvan S. Lewis & Son — ADDRESS: 3319 Olympia Ave

25a. REC'D BY REGISTRAR DATE: FEB 15 1966 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and (a) event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02192 02143

1. PLACE OF DEATH
a. COUNTY: CARROLL MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural Sykesville
c. LENGTH OF STAY IN 1b: 1 YEAR
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 109 E. Hemlock Drive

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Sykesville 06-1
d. STREET ADDRESS: 109 E. Hemlock Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Wade Middle T. Last Thompson, Sr.
4. DATE OF DEATH: Month Feb. Day 11, Year 1966
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1-7-1895
9. AGE (In years last birthday): 71 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Store Owner
10b. KIND OF BUSINESS OR INDUSTRY: Food
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Thomas Thompson
14. MOTHER'S MAIDEN NAME: Lilly Brown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: Mr. Wade Thompson, Jr. Woodbine, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Dec 65 to
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Cardiac Failure
DUE TO (c) Arteriosclerosis - Generalized.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec, 1966, to 2-11, 1966, that (I) (we) last saw the deceased alive on 2-11 1966, and that death occurred at 5:A M, from the causes and on the date stated above.

22a. SIGNATURE: Howard E Hall M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2-12-66
22c. PHYSICIAN'S NAME (Type): Howard E. Hall
22d. ADDRESS: Sykesville, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2-13-66
23c. NAME OF CEMETERY OR CREMATORY: Springfield Cemetery
23d. LOCATION (City, town or county) (State): Sykesville Md.

24. FUNERAL DIRECTOR ADDRESS: Harry W. Haight Sykesville, Md.
25a. REC'D BY REGISTRAR DATE: FEB 15 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02193 02144

1 5 (M)

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): WESTMINSTER
c. LENGTH OF STAY IN 1b: 2 YEARS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 210 E MAIN ST

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER 06-1
d. STREET ADDRESS: 210 E MAIN ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOSEPH Middle ALLEN Last TINKER
4. DATE OF DEATH: Month FEB Day 26 Year 1966
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MARCH 7 1883
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLERK - RETIRED
10b. KIND OF BUSINESS OR INDUSTRY: MERCANTILE TRUST CO.
11. BIRTHPLACE (County & State, or foreign country): BALTIMORE, Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: WILLIAM TINKER
14. MOTHER'S MAIDEN NAME: BARBARA HAGERMAN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): NO
16. SOCIAL SECURITY NO.: 216-03-8041
17. INFORMANT: Address: MRS JOSEPH TINKER WESTMINSTER MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CONGESTIVE HEART FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 6 WEEKS
4221
DUE TO (b): ARTERIOSCLEROTIC CARDIOVASCULAR DIS — 10 YEARS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20. 2De. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
2Df. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from FEB 20, 1966 to FEB 26 19 66 that (I) (we) last saw the deceased alive on FEB 26 19 66, and that death occured at 8:15 P.M, from the causes and on the date stated above.

22a. SIGNATURE: Daniel I Welliver M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2-26-66
22c. PHYSICIAN'S NAME (Type): DANIEL I. WELLIVER
22d. ADDRESS: 14 RIDGE ROAD WESTMINSTER, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3/1/1966
23c. NAME OF CEMETERY OR CREMATORY: New Cathedral
23d. LOCATION (City, town or county) (State): Baltimore, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: H.W. Jenkins & Sons Co.
ADDRESS: 4905 York Road Balto. 12, Md.
25a. REC'D BY REGISTRAR DATE: FEB 28 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02194

CERTIFICATE OF DEATH

02145

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Pullen Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Randallstown 21133 03-2
d. STREET ADDRESS: 8815 Liberty Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Howard — Middle: E — Last: Triplett
4. DATE OF DEATH: Month: Feb. — Day: 3 — Year: 1966
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 17, 1891
9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired chauffer
10b. KIND OF BUSINESS OR INDUSTRY: Balto., asphalt & tile
11. BIRTHPLACE (County & State, or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Edward Triplett
14. MOTHER'S MAIDEN NAME: Sara Catherine Dean
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: 217 05 8471
17. INFORMANT: Mrs. Elsie B. Triplett, 8815 Liberty Rd. Randallstown, 21133

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic asthma; Arteriosclerosis, generalized — INTERVAL BETWEEN ONSET AND DEATH: 1/25/66 until 2/3/66

260 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Diabetes; Cystitis
DUE TO (c): Post operative prostatectomy

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan. 25, 1966 to Feb. 3, 1966, that (I) (we) last saw the deceased alive on Feb. 3 1966, and that death occurred at 9 a.m., from the causes and on the date stated above.

22a. SIGNATURE: Howard E Hall M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Feb. 3, 1966
22c. PHYSICIAN'S NAME (Type): Howard E. Hall, M.D.
22d. ADDRESS: Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: Feb. 6, 1966
23c. NAME OF CEMETERY OR CREMATORY: Jennings Chapel
23d. LOCATION (City, town or county) (State): Howard Co., Md.

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Loring Byers, 8728 Liberty Rd., Randallstown, Md. 21133

25a. REC'D BY REGISTRAR DATE: FEB 7 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M 5-63

Carroll Md. Baltimore

Catonsville

Fallen Nursing Home 8815 Liberty Rd. x

Feb. 3 65

x

1891

male white Dec. 17, 1891 71

life

Retired chauffer Balto., Maryland & Md.

Edward Triplett Sara Catherine Dean

no 217 05 8471 Mrs. Elsie B. Triplett, 8815 Liberty Rd.

Woodlawn, 21133

Burial Feb. 6, 1956 Jennings Chapel Howard Co., Md.

21133

Loring Tyers, 8738 Liberty Rd., Randallstown, Md.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02195

CERTIFICATE OF DEATH

02146

Item 21 Film G576 5/3/66 mh

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Rural) Sykesville
   c. LENGTH OF STAY IN 1b: 1y 2m 5d
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland 21217 — b. COUNTY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City 30-4
   d. STREET ADDRESS: 1602 Booker Court
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Arthur — Middle: Lee — Last: Vaughn

4. DATE OF DEATH: Month: 2 — Day: 9 — Year: 19 66

5. SEX: male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-17-02

9. AGE (In years last birthday): 63 yrs.
   IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): unknown
   (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 218-01-8017

17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bilateral bronchopneumonia
491X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic brain syndrome, with cerebral arteriosclerosis with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): --

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. --- 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State) ---

21. I certify that (I) (this hospital) attended the deceased from 12-4 [illegible] to 2-9, 1966, that (I) (we) last saw the deceased alive on 2-9 19 66, and that death occurred at [illegible] P.M., from the causes and on the date stated above.

22a. SIGNATURE: Heinz H. Klaatsch M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2-10-66

22c. PHYSICIAN'S NAME (Type): Heinz H. Klaatsch, M.D.

22d. ADDRESS: Springfield State Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2-14-66

23c. NAME OF CEMETERY OR CREMATORY: Mt. Auburn

23d. LOCATION (City, town or county) (State): Balto. Md.

24. FUNERAL DIRECTOR: Morton + Dyett F.H.

ADDRESS: 1701 Laurens

25a. REC'D BY REGISTRAR DATE: FEB 14 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02196 02147

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
   c. LENGTH OF STAY IN 1b: 12 days
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Carroll County General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Md. — b. COUNTY: Carroll
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Sykesville
   d. STREET ADDRESS: White Rock Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DURWARD — Middle L. — Last WAITE

4. DATE OF DEATH: Month 2 — Day 22 — Year 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY 10, 1899

9. AGE (In years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Building

11. BIRTHPLACE (County & State, or foreign country): Bradford, Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ? - WAITE

14. MOTHER'S MAIDEN NAME: Retta Mae Rease

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): -

16. SOCIAL SECURITY NO.: 219-28-4311

17. INFORMANT: Mrs Catherine Waite — Address: Above.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIAC ARREST — INTERVAL BETWEEN ONSET AND DEATH: 4 HRS.

4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): ACUTE CORONARY INSUFFICIENCY — 24 HRS
DUE TO (c): HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — YRS.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/10, 1966 to 2/22, 1966, that (I) (we) last saw the deceased alive on 2/22 1966, and that death occurred at 3:22 PM, from the causes and on the date stated above.

22a. SIGNATURE: Vincent J. Ficocci Jr. M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 2/22/66

22c. PHYSICIAN'S NAME (Type): VINCENT J. FICOCCI — 22d. ADDRESS: Westminster, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 2-26-66 — 23c. NAME OF CEMETERY OR CREMATORY: Messiah Lutheran — 23d. LOCATION (City, town or county) (State): Bruceville, Md.

24. FUNERAL DIRECTOR: Luther H. Haight — ADDRESS: Sykesville, Md

25a. REC'D BY REGISTRAR — DATE: FEB 25 1966 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

M 02197 Item 2 Film 0374 3/9/66 mb 02148

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1yr.8mos.29dys.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frederick Mt. Airy 10 - 2
d. STREET ADDRESS: Rt. 2 Montevue Nursing Home
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
MARY	ANN	WELTY	FEBRUARY	25	19 66

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White		9-2-1874	91 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Absolom Hughes	Wilhelmina Kuster

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	214/10/1576	Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: Weeks

446 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Nephrosclerosis — Years

DUE TO (c): Generalized arteriosclerosis — Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): CBS assoc. with senile brain disease, with psychotic reaction

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-26-64, 19 to 2-25-66, 19, that (I) (we) last saw the deceased alive on 2-25-66 19, and that death occurred at 7:00 AM, from the causes and on the date stated above.

22a. SIGNATURE	ATTENDING PHYS. ☐	MED. DIRECTOR ☐	STAFF PHYS. ☒	22b. DATE SIGNED
Dr. Antonius Glahn M.D.				2-25-66

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
Antonius Glahn, M. D.	Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	March 1,1966	Mount Olivet Cemetery	Frederick, Maryland

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Robert L. Dailey Dailey's Funeral Home	1291 N. Market Frederick Md	MAR 2 1966	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02198

CERTIFICATE OF DEATH

02149

1 M

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Mt.Airy
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): R.F.D. # 2

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Mt. Airy
d. STREET ADDRESS: R.F.D. # 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FREDERICK Middle T. Last WRIGHT

4. DATE OF DEATH: Month Feb. Day 20 Year 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Nov.9 1910

9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Building

11. BIRTHPLACE (County & State, or foreign country): Carroll Co. Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: G.Augustus Wright

14. MOTHER'S MAIDEN NAME: Mary Reaver

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 219-03-7767

17. INFORMANT Address: Mrs Grace Wright Same as # 2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: ½ hour
4201
DUE TO (b): ____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): ____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/14, 1965, to Feb, 1966, that (I) (we) last saw the deceased alive on Feb 18 1966, and that death occured at 8 P M, from the causes and on the date stated above.

22a. SIGNATURE: W B Culwell M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/21/66

22c. PHYSICIAN'S NAME (Type): W.B. Culwell

22d. ADDRESS: Mt. Airy, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/23/66

23c. NAME OF CEMETERY OR CREMATORY: Taylorsville Cemetery

23d. LOCATION (City, town or county) (State): Carroll Co. Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: C.M.Waltz Box 241 Sykesville, Md.

25a. REC'D BY REGISTRAR DATE: FEB 24 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02199

CERTIFICATE OF DEATH

02150

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manchester, Maryland.
c. LENGTH OF STAY IN 1b: 8 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Longview Nursing Home, 128 N MAIN St.

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Md
b. COUNTY: Balto.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fruland, Md 03-2
d. STREET ADDRESS: none
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Flora — Middle: Ethel — Last: Young

4. DATE OF DEATH: Month: 2 — Day: 12 — Year: 1966

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Sept 19, 1880

9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: Own home.

11. BIRTHPLACE (County & State, or foreign country): Balto Co - Fruland Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph Walter Young

14. MOTHER'S MAIDEN NAME: Amanda Virginia Rogers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 128-02-9985

17. INFORMANT (niece) Address: Mrs June A Swam Fruland Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Myocarditis
DUE TO (b): Arteriosclerotic Cardiovascular Disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

4221

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year: 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 9, 1965, to February 12, 1966, that (I) (we) last saw the deceased alive on February 12, 1966, and that death occurred at 9:45 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Joseph E Bush M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/13/66

22c. PHYSICIAN'S NAME (Type): Joseph E. Bush MD

22d. ADDRESS: Hampstead Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Febr. 15, 1966

23c. NAME OF CEMETERY OR CREMATORY: Pine Grove Cemetery

23d. LOCATION (City, town or county) (State): Parkton, Md.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Jacob Hartenstein, New Freedom, Pa.

25a. REC'D BY REGISTRAR DATE: FEB 15 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A1S (4)
20M S-63